Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

PROVIDER ADMINISTRATIVE OFFICE MANUAL

Published by Provider Relations and Education, Your Partners in Outstanding Quality, Satisfaction and Service

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PROPRIETARY INFORMATION

The information contained in this provider manual is proprietary.

By accepting this manual, the provider acknowledges it is solely for the purpose of referencing information about the provision of medical services to South Carolina Department of Health and Human Services (SCDHHS) members.

BlueChoice HealthPlan is an independent licensee of the Blue Cross Blue Shield Association.

Links with an asterisk lead to third-party websites. These companies are solely responsible for the privacy policies and content on their sites.

To report provider or member fraud, call Provider Service at 866-757-8286.

You may also call the SCDHHS Fraud Hotline at 888-364-3224 or email **fraudres@scdhhs.gov**.

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INTRODUCTION

Healthy Blue has entered into a contract with the SCDHHS to serve the South Carolina Medicaid population. Healthy Blue provides many of the services required to administer this product. Please read each section carefully.

This manual is available on the website, www.HealthyBlueSC.com, by selecting "Providers."

If new procedures or processes take effect after we publish this manual, Healthy Blue will provide updates through various means of distribution, including but not limited to special mailings and provider bulletins we distribute. Healthy Blue also posts the most recent updates on our website, www.HealthyBlueSC.com.

Providers with questions about the content of this manual should contact Healthy Blue Provider Service at 866-757-8286. This manual does not contain legal, tax or medical advice. Please consult other advisers for such advice.

The information in this manual is intended to be informative and to help providers navigate aspects of participation with the Healthy Blue program. Unless otherwise specified in the provider contract, the information in this manual is not binding upon Healthy Blue and is subject to change. Healthy Blue will make reasonable efforts to notify providers of changes to the content of this manual.

PRIVACY AND SECURITY

Providers and facilities are required to review all member information received from Healthy Blue to make sure it does not include protected health information (PHI). Misrouted PHI includes information about members a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, electronic remittance advices or other digital methods. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained.

We request that providers and facilities that receive the PHI of a person who is not their patient notify us by calling 866-757-8286. We strictly prohibit copying, sharing, using or disclosing the member's PHI.

Healthy Blue uses email monitoring and encryption systems to ensure we keep each member's PHI private and secure. These systems check all outgoing emails the sender doesn't secure. When the system identifies a message with PHI, it automatically secures the email before it is released to the recipient. The receiving party is then notified via email that he or she has a secure message waiting and directed to a secure website where he or she can see the message. If the recipient is accessing the secure site for the first time, he or she will be prompted to create a password-protected account to retrieve this and all future messages.

Healthy Blue uses these tools due to concerns about identity theft. We hope you understand the importance of taking these steps to protect the personal information of patients.

FRAUD, WASTE AND ABUSE

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

Fraud is any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud, regardless of whether it is successful.

Waste includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather it occurs when resources are misused.

Abuse is when health care providers or suppliers do not follow good medical practices, resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

To help prevent fraud, waste and abuse, providers can educate members. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification (ID) card. It is the first line of defense against possible fraud.

Every member ID card lists the following:

- Member's name (subscriber)
- Member's ID number
- Primary care physician's name and telephone number
- Group number
- RxBIN
- RxGroup
- Benefit plan
- Effective date

Presentation of a member ID card does not guarantee eligibility. Verify a member's status by asking online or by phone. Online support is available for provider inquiries on the website. Get phone verification through Provider Service at 866-757-8286.

REPORTING FRAUD, WASTE AND ABUSE

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No one who reports violations or suspected fraud and abuse will be retaliated against for doing so. Investigators will keep the name of the person reporting the incident and his or her callback number in strict confidence.

You can report your concerns by:

- Calling Provider Service at 866-757-8286.
- Calling the SCDHHS Fraud Hotline at 888-364-3224 or sending an email to fraudres@scdhhs.gov.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Be sure to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update the people who make referrals, as it may compromise an investigation.

EXAMPLES OF PROVIDER FRAUD, WASTE AND ABUSE

Examples of provider fraud, waste and abuse include:

- Changing medical records to misrepresent actual services provided.
- Billing for services not provided.
- Billing for medically unnecessary tests or procedures.
- Billing professional services performed by untrained or unqualified personnel.
- Misrepresenting a diagnosis or services.
- Soliciting, offering or receiving kickbacks or bribes.
- Unbundling, which is when multiple procedure codes are billed individually for a group of procedures that should be covered by a single comprehensive procedure code.
- Upcoding, which is when a provider bills a health insurance payer using a procedure code for a more expensive service than was performed.

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.), include:

- Name, address and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Date of events.
- Summary of what happened.

EXAMPLES OF MEMBER FRAUD, WASTE AND ABUSE

Examples of member fraud, waste and abuse include:

- Forging, altering or selling prescriptions.
- Letting someone else use the member's ID card.
- Getting controlled substances from multiple providers.
- Relocating to an out-of-service Plan area.
- Using someone else's ID card.

When reporting concerns involving a member, include:

- The member's name.
- The member's date of birth, Social Security number or case number.
- The city where the member lives.
- Specific details describing the fraud, waste or abuse.

INVESTIGATION PROCESS

We investigate all reports of fraud, waste and abuse for all services provided under the contract. If appropriate, allegations and investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include but is not limited to:

- Written warning and/or education.
  - We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- Medical record review.
  - We review medical records to substantiate allegations or validate claims submissions.
- Special claims review.
  - A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- Recoveries.
  - We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the Special Investigations Unit (SIU), all communication (checks, correspondence) should be sent to:

Attn: Healthy Blue
PO Box 100317
Columbia, SC 29202-3317

Paper medical records and claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator.

Acting on investigative findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste or abuse, the provider:

- Will be referred to the SIU.
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.
- Will be referred to other authorities as applicable and/or designated by the state.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan if the state approves.

RELEVANT LEGISLATION

FALSE CLAIMS ACT

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law that allows the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains qui tam, or "whistleblower," provisions. A whistleblower is a person who reports in good faith an act of fraud or waste to the government or who files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employers under qui tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in health care fraud, and simplifies the administration of health insurance.

Our company strives to ensure both Healthy Blue and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers shall have the following procedures implemented to demonstrate compliance with the HIPAA privacy regulations:

Our company recognizes its responsibility under HIPAA privacy regulations to request only the minimum necessary member information from providers to accomplish the intended purpose. Network providers should request only the minimum necessary member information required to accomplish the intended purpose when contacting us. However, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with access restricted to the people who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.

Do not use internet email, unless encrypted and/or transferred by another secure service, to transfer files containing member information, e.g., Excel spreadsheets with claim information. Mail or fax such information.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific person, post office box or department at our company.

Our company voicemail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.

When contacting us, please be prepared to verify the provider's name, address and tax ID number (TIN) or the member's provider number.

EMPLOYEE EDUCATION ABOUT THE FALSE CLAIMS ACT

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least 5 million dollars (cumulative from all sources) must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse and waste.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse and waste.

MY INSURANACE MANAGER℠

My Insurance Manager is a unique, online tool for providers. They can choose from these options:

- Benefits and Eligibility
- Claims Entry
- Prior Authorization Request and Status
- Claim Status
- Remittance Information
- Your Mailbox
- EDI Reports

My Insurance Manager is a valuable provider tool that can be freely accessed after you have registered with a valid tax ID number in our system. Secure encryption technology ensures any information you send or receive is confidential. It can show you eligibility information and benefits.

My Insurance Manager is not available during weekly maintenance on Sunday evenings from 5 p.m. until midnight.

How to Register. Select the My Insurance Manager tab on www.HealthyBlueSC.com. Choose "Create a Profile," and then enter your tax ID number for BlueCross. Create a username and password. Your profile administrator and each authorized user must have a unique username and password registered in My Insurance Manager. Submit the information. You are now ready to access My Insurance Manager

MY REMIT MANAGER

For years, providers have asked us for the ability to build historical, member-specific remittances that would allow them to sort, view and print these remits through www.HealthyBlueSC.com. Now they can accomplish this using My Remit Manager!

We are offering My Remit Manager at no cost to all providers who want payment faster via electronic funds transfer (EFT) and who will allow us to eliminate paper remittance advices. Of course, we will continue to update the images of the paper remits currently available through My Insurance Manager daily.

My Remit Manager accepts 835s from all commercial BlueChoice® lines of business. It works independently of your practice management system or clearinghouse.

You will be able to:

- View electronic remittance advice (ERA) information by file and see all details. Users have the option of viewing the specific American National Standards Institute details the payer sends or the standardized information in a conventional format.
- Instantly see patient errors and denials. My Remit Manager highlights any claims that have errors or have been denied.
- View information categorized by check numbers or by patient. My Remit Manager clearly lists the name of each patient whose Explanation of Benefits is associated with an individual check or EFT.
- Print individual remits for a single patient. Eliminate the need to remove or black out other patient information on the remit.
- Print remits for selected patients, including individual or group remits.

Get started by contacting our EDI team at EDI.Services@bcbssc.com. We will e-mail you the information you need to get registered.

IMPORTANT CONTACT INFORMATION

Name	Phone Number	Fax Number	Email/Website
Provider Service	866-757-8286	N/A	www.HealthyBlueSC.com My Insurance Manager
24-Hour Nurseline	800-830-1525	N/A	N/A
Utilization Management	866-757-8286	800-823-5520	www.HealthyBlueSC.com My Insurance Manager
Case Management	866-757-8286	803-870-6501	N/A
Technology Support (MIM)	855-229-5720	N/A	N/A
SCDHHS Fraud Reporting	888-364-3224	803-255-8224	fraudres@scdhhs.gov
Vision Service Plan (VSP) VSP is an independent company providing vision services on behalf of Healthy Blue.	800-615-1883	N/A	www.vsp.com
CarelonRx CarelonRx is an independent company providing pharmacy management services on behalf of Healthy Blue.	844-410-6890	844-512-9005	N/A
DentaQuest LLC DentaQuest is an independent company that provides dental services on behalf of BlueChoice HealthPlan.	800-782-5150	800-521-1735	www.DentaQuest.com
Modivcare Modivcare is an independent company that provides transportation services on behalf of Healthy Blue.	Region 1: 866-910-7688 Region 2: 866-445-6860 Region 3: 866-445-9954 Please view website to verify which region the member reside in	N/A	www.Modivcare.com/facilities/sc
Avalon Avalon is an independent company that manages the prior authorizations for laboratory services on behalf of BlueChoice HealthPlan.	844-227-5769	813-751-3760	www.avalonhcs.com
National Imaging Associates (NIA) National Imaging Associates is an independent company that manages the prior authorizations for radiology and high-tech imaging services on behalf of BlueChoice HealthPlan.	855-569-6749	N/A	www.RadMD.com
Provider Enrollment	N/A	N/A	My Provider Enrollment Portal

MEDICAID MEMBER BENEFITS

What is Medicaid?

Medicaid is a health and long-term care coverage program jointly financed by the state and federal governments. Each state establishes and administers its own Medicaid program and determines the type, amount, duration and scope of services covered within broad federal guidelines. States must cover certain benefits and may choose to provide other benefits.

The SCDHHS administers the Medicaid program in South Carolina. It ensures the availability of government-funded health care services for eligible members. In South Carolina, certain traditional Medicaid fee-for-service programs through the SCDHHS exist, but Medicaid members can choose a health plan, also known as a managed care organization (MCO).

Healthy Blue provides health care benefits to SCDHHS-eligible members. The benefits focus on access, prevention and education. Healthy Blue offers the MCO model to help manage member health care services beginning at the primary care level to:

- Increase access to primary and preventive care.
- Increase access to appropriate specialty care and improve overall coordination of care for our members.
- Improve health outcomes and improve quality of life for our members.
- Improve the overall cost effectiveness of the Medicaid program and be wise stewards of state dollars.

In addition, at no cost to members, Healthy Blue offers many value-added services not available through the traditional fee-for-service program.

Note: Healthy Blue notifies providers of significant program changes, including network changes, at least 30 days prior to the effective date.

How Healthy Blue educates its members, your patients

Healthy Blue is aware that members may not fully understand how to effectively access and use their Medicaid managed care benefits. In addition, they may not be aware that Healthy Blue can help them in understanding how to use their health plans to get the most out of those benefits.

Therefore, Healthy Blue implemented the following for member education:

- Healthy Blue sends members an ID card with key phone numbers and information on how to use their plans.
- Healthy Blue sends new members kits that include useful information, such as:
  - How to use the health plan.
  - Explanation of covered and noncovered services, including emergency services.
  - Primary care provider (PCP) listing.
  - Health education information, including information for pregnant members.
  - Explanation of the 24-Hour Nurseline, the health information line, and its importance to Healthy Blue members.
- Healthy Blue sends newsletters with key health topics and information.
- Healthy Blue has a public website and a secure portal where members can look up information about benefits, services, contact information and more at www.HealthyBlueSC.com.

COVERED BENEFITS

Members may be subject to copays for certain services as indicated in the Medical Services Benefits Matrix. However, members who fall into these categories are exempt from any copays:

- Children under 19 years of age
- Pregnant women and individuals receiving family planning services
- Institutionalized individuals (nursing facilities or intermediate care facilities for individuals with intellectual disabilities) For additional details, see Chapter 6, “Other Types of Services” under Skilled Nursing Facilities (SNF)
- Individuals receiving emergency services
- Individuals receiving Medicaid hospice benefits
- Federally recognized Native Americans and Alaskan natives (do not pay most copays)
- Tribal members (do not have copays for services from the Catawba Service Unit in Rock Hill, South Carolina, or when referred to a specialist or other medical provider by the Catawba Service Unit)

Copays do not apply to these services:

- Preventive care visits
- Urgent care visits
- Medical equipment and services provided by the South Carolina Department of Health and Environmental Control (DHEC)
- Family planning care
- End-stage renal disease care
- Infusion center care
- Early and periodic screening, diagnosis and treatment (EPSDT) well-child visits/services
- Rehabilitative behavioral health services
- Emergency room (ER) visits in the U.S.

Also, members do not have prescription copays for:

- Family planning medicine, such as birth control.
- Smoking cessation drugs.
- Behavioral health drugs.
- Certain diabetic medications.
- Three-day emergency supplies of 17-P injections.
- Antibiotics and antivirals, including those for including HIV.
- Certain hypertension medications.
- Certain cholesterol medications.
- Naloxone.

MEDICAL SERVICES

On a case-by-case basis, Healthy Blue may approve services and benefits exceeding the limitations listed in this Medical Services Benefits Matrix.

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Audiological services Limitations: • Only covered for children under 21 years of age Prior authorization is required.	Services include: • Diagnostic services. • Screenings. • Preventive services. • Corrective services. • Hearing aids and supplies.
Behavioral health/substance use Copay of $25 for inpatient hospitalization RBHS services that require authorization include: • H0038, H2014, H2017, H2030, H2037 and S9482. • Authorization requests should include the authorization form, diagnostic assessment, treatment plan and any additional clinical information that supports the request. Refer to the above BH section to see the approved provider types. Limitations: • Psychiatric assessments = one per member per provider every six months – Additional assessments may be approved when medically necessary. • Individual and group counseling for help quitting smoking = four sessions per quit attempt and two quit attempts per year	Inpatient services: • Behavioral health and substance use services at contracted facilities Outpatient services: • Psychiatric diagnostic interview exams • Psychotherapy (group, family and individual) • Psychological testing • Rehabilitative behavioral health services (adults and children) Substance use services: • Social detoxification • Residential • Partial hospitalization • Intensive outpatient program • Psychiatric diagnostic interview exams • Medication assisted treatment services • Tobacco cessation services: – Bupropion for tobacco use – Varenicline – Nicotine gum, lozenge, nasal spray, inhaler and patch • One-on-one phone and web-based counseling through the Tobacco Quitline, 800-QUIT-NOW Counseling in individual and group settings: • Rehabilitative behavioral health services • Psychological rehabilitative services
Chiropractic services Copay of $1.15 Limitation: • Chiropractic visits = six per member per benefit year	Chiropractic services are available to all recipients and are limited to manual manipulation of the spine to correct a subluxation. Chiropractic visits are counted separately from the ambulatory visit limit. Codes covered: • 98940 – 98942 (from the SCDHHS manual) • Radiology: 72010, 72040, 72070, 72080 and 72100

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Chronic renal disease	Services include: • Hemodialysis. • Peritoneal dialysis. • Other dialysis procedures.
Communicable disease services	Services include: • Exams and reviews. • Teaching about health topics. • Counseling. • Contact tracing. • Certain outreach for direct observation therapy for tuberculosis.
Dental services Copay of $3.40 Limitation: • No copays for emergency services **Note: All routine dental services are handled through Healthy Connections via DentaQuest.** DentaQuest is an independent company providing dental benefit management services on behalf of BlueChoice HealthPlan.	Services include: • Routine dental care, oral exams, cleanings, X-rays and fluoride treatments for members under 21 years of age. • Up to $750 per year for covered dental services like oral exams, cleanings, X-rays, extractions, fillings and medically necessary procedures from an oral surgeon for members ages 21 and older. • Anesthesia for emergency dental services.
Developmental evaluation services Limitations: • Neurodevelopmental assessments = 12 units per year • Neurodevelopmental reassessments = four units per visit • Psychological evaluations = 12 units per year • Psychological reevaluations = 12 units per year and one per six months	Neurodevelopmental or mental developmental assessments and testing for eligible members under 21 years of age: • Neurodevelopmental assessments • Neurodevelopmental reassessments • Psychological evaluations • Psychological reevaluations • Pediatric day treatment

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Durable medical equipment (DME) and disposable supplies Copay of $3.40 per item Note: Healthy Blue does not collect the DME copay on rent-to-own equipment. Limitations: • Diabetic shoes = one pair • Diabetic shoe inserts = three pairs • Prior authorization (PA) requirement on some equipment • Hearing aids and accessories covered for members under 21 years of age • No coverage for wheelchair accessories that are not medically necessary, including but not limited to crutch or cane holders, umbrellas, pillows and similar accessories • PA requirement for insulin pumps for members with Type 1 diabetes • Nondisposable underpants = 24 per year • Disposable underpants = one case per month • Adult disposable incontinence brief/diaper = 96 per month • Adult disposable incontinence protective underwear/pull-on = 80 per month • Pediatric disposable incontinence brief/diaper = 96 per month • Pediatric disposable incontinence protective underwear/pull-on = 80 per month • Youth disposable incontinence brief/diaper = 96 per month • Youth disposable incontinence protective underwear/pull-on = 80 per month • Disposable inner/shield/guard/pad/undergarment for incontinence = 130 per month • Disposable incontinence brief/diaper, bariatric = 96 per month	Medically necessary equipment and supplies, including: • Medical products, including office-based injectables • Surgical supplies • Wheelchairs – Power wheelchairs may be replaced every seven years. • Traction equipment • Walkers • Canes • Crutches • Ventilators • Prosthetic and orthotic devices • Oxygen • Hearing aids and accessories • Diabetic supplies – Quantity limits apply. • Insulin pumps for members with Type I and 2 diabetes • Incontinence supplies – Coverage is subject to change and requires authorization. Call 866-757-8286 for details and authorization.)
Early and periodic screening, diagnosis and treatment services (EPSDT) Limitation: • Services end at the end of the birth month of a child's 21st birthday.	Preventive health care services, including: • Health screenings • Comprehensive health and development history • Developmental assessments • Comprehensive unclothed physical exams • Appropriate immunizations • Dental assessments • Vision screenings • Hearing screenings • Anemia screenings • Blood pressure checks • Lead toxicity screenings • Laboratory tests

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Emergency services	All services that are considered emergencies are covered in the U.S. Services received outside of the U.S. are not covered.
Emergency transportation A run report must be maintained in the provider's files for each claim and is subject to audit review as requested.	Emergency transportation provided by: • Ambulance • Air ambulance
Family planning services and supplies Limitations: • The following services are not covered: – Surgery to reverse sterilization – Hysterectomy for sterilization reasons – Fertility treatments, such as artificial insemination and in-vitro fertilization – Abortions Note: Bill Healthy Blue directly for family planning services and supplies from an out-of-network Medicaid provider.	Services to help prevent unintended or unplanned pregnancies, including: • Exams • Assessments • Diagnostic procedures • Pregnancy testing • Lab services related to family planning • Health education and counseling services • Contraceptive drugs and supplies • Nontherapeutic sterilizations (tubal ligations) Note: Sterilizations and hysterectomies require 1 – 2 completed forms.
Federally Qualified Health Center (FQHC) and rural health center (RHC) services Copay of $3.30	Services include: • Preventive care. • Primary care. • Communicable disease services to help control and prevent disease.
Home health services Copay of $3.30 Limitations: • 50 visits per benefit year • Personal care services excluded	Services include: • Intermittent skilled nursing. • Home health aide services. • Physical, occupational and speech therapy services. • Physician-ordered supplies. • Incontinence supplies.

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Hospital inpatient services Copay of $25 Limitation: • Private rooms are not covered unless medically necessary.	Services include: • A semiprivate room. • Maternity services. • Special treatment rooms. • Operating rooms. • Supplies. • Medical tests and X-rays. • Drugs the hospital gives during stay. • Blood transfusions. • Radiation therapy. • Chemotherapy. • Dialysis treatment. • Meals and special diets. • General nursing services. • Anesthesia. • Anesthesia for dental procedures when it is an emergency. • Setting up a plan for when you leave the hospital, including future care if you need it. • Rehabilitation in the hospital. • Surgery to repair the breast after a complete or partial removal for any medical reason.
Hospital outpatient services • Hospital services (other than emergency services): copay of $3.40 for all members over the age of 19 • Nonemergent services in the ER: copay of $3.40 for all members over the age of 19 • Ambulatory surgery clinic: copay of $3.30 for all members over the age of 19 • Individual rehabilitative services (speech and other language therapy, occupational therapy, or physical therapy): copay of $3.40 Limitations: • Neurodevelopmental and/or psychological developmental assessment and testing is limited to eligible members under 21 years of age. • Members who are 21 years of age and older have a limit of 75 combined visits or 300 units per benefit year. • Members who are under 21 years of age receiving therapy are limited to 105 combined visits or 420 units per benefit year. • Any services beyond the benefit maximum will need medical review and PA	Services rendered in an outpatient/ambulatory care facility, such as: • Preventive services • Diagnostic services • Therapeutic services • Surgical services • Emergency services • Mental health services • Substance abuse services • Treatment of renal disease • Neurodevelopmental and/or psychological developmental assessment and testing • Individual rehabilitative services, such as speech and other language therapy, occupational therapy or physical therapy • Family planning services and supplies

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Hysterectomies and abortions Abortion requires submission of complete medical records that document the reason or need for the abortion.	Services include: • Nonelective, medically necessary hysterectomies • Abortions and related services to save the life of the mother or for pregnancy resulting from rape or incest Sterilizations require one completed form: • Consent for Sterilization form (HHS-667) Hysterectomies require two completed forms: • The Consent for Sterilization form (HHS-687) • The Surgical Justification Review for Hysterectomy form Abortions require a completed Abortion Statement form. A certification statement is required in cases of rape or incest. Find these forms at www.HealthyBlueSC.com
Independent laboratory services	Laboratory services ordered by a physician
Institutional long-term care facilities/nursing homes Limitations: • Coverage is limited to 90 continuous days of confinement. • The Medicaid fee-for-service Program covers payments after the first 90 days. • Initial Review — Submission to Health Plan of the completed and signed, Form 185 — Level of Care Certification Letter. • Concurrent Review – Submission to Health Plan of the completed and signed, Form 185 — Level of Care Certification Letter, with the new effective and expiration Dates. For additional details, see Chapter 6, "Other Types of Service" under "Skilled Nursing Facilities (SNF)."	Services provided in a long-term care facility, nursing home or hospital with swing beds or administrative days Services include: • Nursing facility and rehabilitative services at the skilled intermediary or sub-acute level of care.

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Maternity services • There is no copay for prenatal visits and routine care for pregnant members. • Notification of pregnancy is required after the first prenatal visit. • Notification of delivery (NOD) by the facilities is required within 24 hours after birth using the NOD or agreed-upon format. Information includes date of birth, gestational age, live birth, weight and gender.	Services include: • Referrals to maternal fetal medicine specialists for high-risk pregnancy and after-delivery care when medically necessary. • Limit of three routine prenatal ultrasound anatomic surveys per pregnancy. – Additional prenatal ultrasound procedures require a medical diagnosis code and/or PA that supports the procedure being performed. This policy does not apply to ultrasounds performed by maternal/fetal medicine specialists in hospital settings or by radiology providers. • Sonograms. • Services from a certified nurse-midwife. • Tests such as HIV testing, treatment and counseling – A pregnant member may refuse to take an HIV test. • CenteringPregnancy prenatal care group visits for female members 12 – 55 years of age. – This is prenatal care in a group setting to discuss maternal and infant health as a group while receiving clinical supervision and support. – Group clinical visits must last at least 1.5 hours and have 2 – 20 clients. – Up to 10 group clinical visits prior to delivery may be covered. – The Centering Healthcare Institute lists sites in South Carolina currently approved to provide CenteringPregnancy services. • Birthing center services. • Hospitalizations and delivery, including vaginal and cesarean section. • Newborn exams. • Newborn hearing screenings. • Post-operative visit after a C-section. • Postpartum visit between 7 – 84 days. • Electric breast pump for mothers who wish to breastfeed and are not able to due to mother's or infant's medical condition. • Long-term electric breast pump needs with a hospital-grade electric breast pump rental for mothers with a baby in the neonatal intensive care unit.

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Nonemergent transportation Limitations: • We do not cover transportation, such as: – Airplane. – Private automobile. – Taxi. – Bus.	Services include: • Transfer from a hospital to another hospital, facility or the member's home. • Transport to an out-of-state medical facility if we approved the referral.
Outpatient pediatric AIDS clinic services	Services for HIV-infected and exposed children and families include: • Specialty care. • Consultations. • Counseling services. • Clinical and lab tests.
Physician services • Copay of $3.30 • Specialist visits (physician, nurse practitioner or licensed midwife): copay of $3.30 Note: Copays do not apply to certain members and services. See more information in the Covered Benefits section. Limitations: • We do not cover routine physicals for a job or camp program. • Routine physicals for children until the end of the month of the member's 21st birthday. • Adult well-visits for members over age 21 covered every two years.	Services include: • Preventive care. • Primary care. • Specialty care. • Communicable disease services to help control and prevent disease.
Podiatry services Copay of $1.15 for members 19 – 20 years of age Limitations: • Benefit covers children under the age of 21. • Benefit covers members 21 years of age and older only if they are diagnosed with diabetes. Please bill Healthy Blue directly for these services, not the SCDHHS. For more information, please call Provider Service at 866-757-8286 Monday – Friday from 8:30 a.m. – 5 p.m. or visit us online any time at www.HealthyBlueSC.com	Services include: • Podiatric surgical procedures. • Routine foot care. • Cutting or removal of corns and calluses. • Nail trimming. • Hygienic and preventive maintenance care. • Diagnosis and treatment of diabetic ulcers, wounds and infections.

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Prescription drugs Copay of $3.40 per prescription/refill on brand- name and generic medications for members ages 19 and older See the section above for copay exceptions. Limitations: • There are no limits on the number of prescriptions, but some medications may require PA. • Substances that are not controlled are limited to a 31-day supply. • Home delivery optional benefit is available for maintenance medications for a 31-day supply. • An extended-day/90-day supply may be available for select drugs in four drug categories — asthma, cholesterol, oral diabetes and hypertension — through the home delivery optional benefit. • Over-the-counter medicine is only covered with a prescription. • Diet aids, cosmetic or hair growth drugs, erectile dysfunction drugs, and drugs for infertility are not covered. • Over-the-counter drugs are limited to those on our Prescription Drug list (PDL). • Syringes or needles not used for self-administered injectable medications are listed under the medical benefit, not the pharmacy benefit. • Certain hemophilia drug requests must be reviewed by Healthy Blue for PA. • Specialty medications need to be dispensed through a preferred specialty pharmacy	Refer to the PDL for a list of covered drugs. To view the PDL, visit www.HealthyBlueSC.com.
Preventive and rehabilitative services for primary care enhancement Limitation: • Benefit covers individual rehabilitative services (physical, occupational, speech and language therapy).	Available to members determined to have medical risk factors Services include: • Assessment/evaluation of health status. • Identification of relevant risk factors. • Development/revision of a goal-oriented plan of care. Note: CPT code 97352 (Cognitive rehabilitation to improve attention, memory and problem solving) requires PA.
Psychiatric assessment services Limitations: • One assessment per member every six months – Additional assessments may be approved when medically necessary.	Services include: • Psychiatric diagnostic interview exams. • Interactive psychiatric interview. • Behavioral health services given in the ER.

Medical Services Benefits Matrix	
Benefit/Limitation	**Scope of coverage**
Transplant services Some transplants and related care are covered by S.C. Healthy Connections Medicaid. Others are covered by Healthy Blue If the transplant is approved, the QIO (KePro) approval letter serves as authorization for pretransplant services (72 hours preadmission), the transplant (hospital admission through discharge) and post-transplant services up to 90 days from the date of discharge. Note: All transplant services, except corneal and kidney transplants, must be approved by the Quality Improvement Organization (QIO) before you get the service. QIO is an organization SCDHHS has contracted to approve transplant services. The QIO will review Medicaid referrals for organ transplants and issue an approval or a denial.	Healthy Blue covers all services for corneal and kidney transplants. Healthy Connections Medicaid covers kidney and all other transplants events. Healthy Blue covers services needed before and after the transplant. This includes: • Pre-transplant services 72 hours prior to pre-admission • Post-transplant follow-up services • Post-transplant pharmaceutical services After PA review by the SCDHHS-contracted QIO, fee-for-service Medicaid covers transplant services except for: • Kidney: Healthy Blue is responsible for all services 72 hours prior to admission, post-transplant services upon Medical University Hospital Authority (MUHA) discharge and post-transplant pharmacy services. Fee-for-services Medicaid covers the kidney transplant. • Corneal: Healthy Blue is responsible for the transplant, related pre- and post-transplant services and for post-transplant pharmaceutical services. • Bone marrow (autologous inpatient and outpatient, allogenic related and unrelated, cord, and mismatched), pancreas, heart, liver, liver with small bowel, liver/pancreas, liver/kidney, kidney/pancreas, lung and heart/lung, multivisceral and small bowel: Healthy Blue is responsible for all related services 72 hours prior to admission, post-transplant services (upon discharge) and post-transplant pharmacy services. Fee-for-services Medicaid covers the bone marrow transplant.
Vaccinations **Note: For children (through 18 years of age), vaccinations are covered by the Vaccines for Children program.**	Coverage for adults (19 years of age and older) includes: • Serogroup B meningococcal (MenB). • Measles, mumps and rubella (MMR) • Varicella (VAR). • Measles, mumps, rubella and varicella (MMRV).
Vision services • No copay for routine vision services • Copay of $3.30 for members 19 years of age and older who see an optometrist or ophthalmologist (eye doctor) for medical reasons **Note: Healthy Blue covers benefits only when a VSP network provider delivers the services. (Please see the Vision Services section for a partial list of VSP billable codes.) Bill claims for these services directly to VSP.** Providers with questions about other medically necessary vision services should contact Provider Service at 866-757-8286.	Coverage for members under 21 years of age: • One eye exam every 12 months • One pair of eyeglasses (frames and lenses) and related fitting every 12 months Coverage for members 21 years and older : • One routine eye exam every 12 months • A pair of eyeglasses (frames and lenses) and related fitting every 24 months
X-ray services	Refer physician-ordered X-ray services to an in-network provider of X-ray services.

EXCLUDED SERVICES

Below is a partial list of services that Healthy Blue and fee-for-service Medicaid do not cover:

- Personal care services
- Medical equipment and supplies used only for member comfort or hygiene
- Exercise equipment
- Care for work-related injuries that is covered by the member's employer or workers' compensation
- Services and supplies that are not medically necessary
- Private-duty nurses
- Acupuncture
- Syvek® patch
- Services rendered outside the United States
- Cosmetic surgery, unless it is done to repair use of a body part or correct a defect caused by injury

EXPANDED BENEFITS

In addition to the regular Medicaid benefits and services through the state, Healthy Blue provides the following expanded benefits:

- 24/7 health information through our 24-Hour Nurseline at 800-830-1525
- No-cost adult vision care for members ages 21 and up, annual eye exams and glasses (frames/lenses) every other year
- No-cost GED Ready® exam for members ages 17 and up
- No copays for preventive and urgent care visits for members ages 21 and up
- No referrals needed to see in-network specialists
- No-cost Girl Scout membership plus discounts toward program materials for eligible members ages 5 – 18
- No-cost Youth Explorer Program through Boy Scouts of America for members ages 8 – 18
- No-cost smartphone with monthly minutes, data, and text messages
- Healthy Blue Community Resource Link to find resources in the community by ZIP code
- Discounts on Boys & Girls Club fees for eligible members ages 6 – 18 at participating clubs
- Books for Babies℠
  - Members may request a $35 Barnes and Noble gift card that they can use to buy their choice of books for their baby age 2 years or younger
- No-cost medication synchronization program to help members get prescriptions on the same day each month
- No-cost internet essentials program in participating areas
- No-cost sports physical for members ages 6 – 18
- No-cost coupon booklet with discounts to local retailers
- No-cost headset learning gear for members 5 – 18
- Low-cost or no-cost over-the-counter (OTC) medicines with a prescription
- No-cost flu shots for eligible family members 19 years and older at plan pharmacies
- No-cost Chronic Condition Care Program for members with long-term health issues
- Discounts on nutritional supplements, allergy products, fitness centers, alternative health specialists and Jenny Craig®
- $20 Uber gift card or no-cost annual oil change for members over 18 in case management
- Fresh fruits and vegetables for two months for members diagnosed with diabetes
- No-cost food delivery for postpartum moms in case management
- Tutoring
  - Eligible members will get a $50 voucher they can use to pay for educational support courses from Outschool.com.
- Asthma toolkit for qualifying members
- Community events with food, games and prizes

- Benefits for pregnant members and new parents:
  - No-cost car seat for their new baby by going to prenatal visits
  - Sam's Club membership for new moms by going to prenatal visits
  - No-cost case of diapers for newborn members up to 15 months with well-child checkup
  - Healthy Rewards reloadable card to use at certain retail stores for going to prenatal and well-child checkups
  - No-cost electric breast pump for breastfeeding moms
  - No-cost prenatal program with pharmacy and nutritional counseling
  - No-cost referrals for in-home nurse care before and after delivery

BabyNet

BabyNet is South Carolina's early intervention system for infants and toddlers ages 3 and under with developmental delays or who have conditions associated with developmental delays. Providers interested in enrolling must submit the following documents to the SCDHHS BabyNet State Office to establish their BabyNet Agreements:

- BabyNet Provider Enrollment Form
- BabyNet Individual User Confidentiality Agreement
- Drug-Free Workplace Statement
- W-9 form**
    - Required to be enrolled in Medicaid*
- National Provider Identifier (NPI) number*
- Proof of current liability insurance*
- Current licensure*
- Background check (issued within the last 365 days)
    - Office of Inspector General (OIG)
    - Sex Offender Registry
    - Nationwide Criminal Report
    - Social Security Number Verification
    - Residency History Check
    - Professional License Verification*

*Not required for interpreters.

**Not required for rendering providers.

Email all documents and questions to BABYNET (scdhhs.gov) or mail them to:

SCDHHS BabyNet State Office, Room 400
Attention: Provider Enrollment
1801 Main St.
Columbia, SC 29201

BabyNet covered services

All current Medicaid services are included in BabyNet. The table includes a list of covered BabyNet codes.

Service category	Procedure code
Audiology Evaluation	92557
Audiology Services	92550
Audiology Services	92551
Audiology Services	92552
Audiology Services	92553
Audiology Services	92555
Audiology Services	92556
Audiology Services	92563
Audiology Services	92567
Audiology Services	92570
Audiology Services	92579
Audiology Services	92582
Audiology Services	92583
Audiology Services	92584
Audiology Services	92585
Audiology Services	92586
Audiology Services	92590
Audiology Services	92591
Audiology Services	92592
Audiology Services	92593
Audiology Services	V5725
Audiology Services	V5011
Audiology Services	V5264
Audiology Services	V5090
Occupational Therapy Evaluation	97165
Occupational Therapy Evaluation	97166
Occupational Therapy Evaluation	97167

Service category	Procedure code
Occupational Therapy Evaluation	97168
Speech-Language Evaluation/Reevaluation	S9152
Speech-Language Evaluation/Reevaluation	92521
Speech-Language Evaluation/Reevaluation	92522
Speech-Language Evaluation/Reevaluation	92523
Speech-Language Evaluation/Reevaluation	92524
Speech-Language Evaluation/Re-evaluation	92610
Speech-Language Services	92507
Speech-Language Services	92526
Speech-Language Services	92609
Physical Therapy Evaluation	97161
Physical Therapy Evaluation	97162
Physical Therapy Evaluation	97163
Physical Therapy Evaluation	97164
Physical Therapy Evaluation	97168
Physical Therapy Services	97110
Physical Therapy Services	97530
Autism Evaluation	97151
Autism Services	97153
Autism Services	97155
Autism Services	97156
Vision Evaluation	92002
Vision Evaluation	92004
Vision Evaluation	92012
Vision Evaluation	92014
Vision Services	92015

PHARMACY BENEFITS

CarelonRx administers pharmacy benefits to members who are enrolled in Medicaid for Healthy Blue. These benefits cover outpatient prescription drugs received through a retail pharmacy based on medical necessity.

There are no limits on the number of prescriptions, but some medications may require PA.

Copays

Healthy Blue members ages 19 and older have pharmacy copays of $3.40 per prescription/refill on brand-name and generic medications.

Note: Refer to the section that covers the copay exemptions.

Pregnant women

Pregnant members are exempt from copays. In some circumstances, it may be necessary for the pharmacy to enter a “2” in the Prior Authorization Type Code field to identify the prescription as exempt from copay.

Quantity supply

We limit certain medications to a one-month supply (maximum 31-day supply). Select drugs in four categories may be eligible for an extended-ay/90-day supply: asthma, cholesterol, oral diabetes and hypertension. If a medical condition warrants a greater supply than the defined one-month supply of medication, submit a PA request for review for coverage of the increased quantity.

Members should refer to their Evidence of Coverage (EOC) for benefit details, exclusions and limitations.

For a PA form for quantity supply, go to www.HealthyBlueSC.com.

Brand-name versus generic products

The pharmacy benefit for Healthy Blue members is a mandatory generic program for brand-name products that have an equivalent generic. Brand-name products are available, if medically necessary, through the PA process.

Pharmacy Lock-In Program

In the interest of patient safety, Healthy Blue monitors members' usage of pharmacy services and provider visits to make sure their drug therapies, where applicable, are appropriate and coordinated with their other care. If this monitoring reveals a member's potential overuse of providers, pharmacies and prescription medications within a narrow time frame, the member is referred to the Pharmacy Lock-In Program and assigned to a single pharmacy for all drug therapy requirements.

Once we assign a member to a single pharmacy, Healthy Blue notifies the member of the assignment by letter. This notification letter includes the assigned pharmacy's contact information as well as a brief explanation of our action. Additionally, this letter notifies the member of the option to file an appeal if the member does not agree with our decision to restrict pharmacy access. Healthy Blue also sends a letter to the assigned pharmacy notifying them of the assignment and the reasons why we are restricting that member's pharmacy access.

An emergency exception can be made to assure the provision of necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication prescribed or when a new prescription is medically needed at a time when the assigned pharmacy is closed. Healthy Blue can allow for a 72-hour emergency supply of medication to be filled by a pharmacy other than the designated lock-in pharmacy.

If you have questions about the Pharmacy Lock-In Program, please contact Provider Service at 866-757-8286.

Preferred Drug List (PDL)

The PDL is used to administer pharmacy benefits for Healthy Blue members. The goal of the PDL is to ensure Healthy Blue members receive therapeutically appropriate and cost-effective drug therapy. Since the PDL promotes rational, scientific care based on consideration of published clinical studies, Food and Drug Administration (FDA) data, community standards, and cost-benefit evaluations, it serves as a primary reference in the selection of medications for Healthy Blue members. The PDL is reviewed and, as necessary, updated once per quarter. Providers should always refer to www.HealthyBlueSC.com for an accurate PDL.

If a member leaves another plan or regular Medicaid to join Healthy Blue, Healthy Blue must honor existing prescriptions needing a PA under the new Plan's formulary for up to 90 days. Please note, a member is only allowed a one-time fill for a 30-day supply during the transition period.

Medications not on the PDL are available, if medically necessary, through the PA process. To view the PDL, visit www.HealthyBlueSC.com.

Over-the-counter (OTC) medications

We cover select OTC medications under the pharmacy benefit when prescribed by a licensed practitioner as a less expensive alternative to covered prescription medications. This includes:

- Analgesics
- Antacids.
- Anti-diarrheals.
- Antihistamines, including generic loratadine.
- Anti-inflammatories.
- Anti-ulcer medications, including Prilosec OTC®.
- Benzoyl peroxide for acne.
- Contraceptive devices (condoms, spermicidal foams and creams).
- Hematinics.
- Hydrocortisone.
- Laxatives/stool softeners.
- Pediatric vitamins.
- Pediculicides.
- Prenatal vitamins.
- Smoking cessation products (generic nicotine patches and gums).
- Topical anti-fungal preparations.
- Topical antibiotics.
- Topical anti-parasitics.
- Vaginal anti-fungal preparations.

To view commonly covered OTC medications, visit www.HealthyBlueSC.com.

Medical devices

Most medical devices should be billed through the medical benefit when medically necessary.

Phenylketonuria (PKU)

Enteral supplements are not a pharmacy-covered benefit except for enteral supplements for PKU. All other supplements should be billed through the medical benefit when medically necessary.

Contraceptives

The pharmacy benefit covers oral contraceptives, contraceptive devices, and OTC contraceptives. Injectable contraceptives and implantable devices, however, are available through the medical benefit only.

Immunizations and vaccines

Coverage for children through 18 years of age continues to be provided through the Vaccine for Children (VFC) Program. The SCDHHS continues to reimburse for the administration of age-appropriate vaccinations provided to children when they get the vaccine through the VFC Program.

Healthy Blue covers certain pharmacy vaccines for people 19 years of age and older as part of the pharmacy benefit. These vaccines include:

- Flu.
- Pneumonia.
- Shingles.
- Measles, mumps and rubella.
- Varicella.
- Meningococcal.
- Measles, mumps, rubella and varicella.
- Tetanus, diphtheria and pertussis.

The COVID-19 vaccine is available for all eligible members through the pharmacy benefit.

SPECIALTY MEDICATIONS

Specialty medications are high-cost injectable drugs that generally require close supervision and monitoring of the drug therapy. These drugs often require special handling, such as temperature-controlled packaging and overnight delivery. They are often unavailable at retail pharmacy stores.

Office-based injectables are typically covered under the medical benefit, while self-injectable medications are typically covered under the pharmacy benefit program. Self-injectable medications are limited to a maximum 31-day supply per fill. Certain medical injectable drugs require PA. To determine whether the medical injectable you are prescribing requires a PA, please refer to the Medical Injectable Drug List on our website at www.HealthyBlueSC.com.

SPECIALTY PHARMACY

Healthy Blue uses a separate specialty pharmacy network for dispensing specialty medications that are covered under the pharmacy benefit. Our participating specialty pharmacy vendors provide distinct care when a specialty drug is dispensed. In addition, these pharmacies enable members who have complex medical conditions to stay compliant with their specialty drug regimens.

A list of participating specialty pharmacies is on our website at www.HealthyBlueSC.com.

Members can receive their initial (first fill) specialty medication supply at a local retail pharmacy in urgent situations that cannot wait for shipping from a specialty pharmacy.

Prior authorizations (PA)

Visit www.HealthyBlueSC.com for detailed information about Pas for services, specific procedures, and other general items and benefits.

PA guidelines

Select medications on the PDL may require PA. Medications must meet FDA-approved indications and Healthy Blue guidelines. If a medication requires PA, the prescriber needs to complete a PA form for submission to Healthy Blue. Alternatively, providers can request PA by calling the Prior Authorization of Benefits Call Center at 844-410-6890.

Electronic PA requests can be submitted using CoverMyMeds by visiting www.CoverMyMeds.com.*

CoverMyMeds is an independent company that provides an electronic PA tool on behalf of BlueChoice HealthPlan.

To get PA forms, go to www.HealthyBlueSC.com. Fax PA forms to the Prior Authorization of Benefits Call Center at 800-823-5520.

PA review times

PA requests are reviewed and notification of a decision is made within 24 hours of receipt of a completed request.

To ensure timely processing of requests, all relevant clinical information and previous drug history must be included and/or provided with the request.

Emergency supply

Healthy Blue network pharmacies may provide a 72-hour emergency supply of medication to members who have an immediate need to start a medication that is being reviewed for coverage through the PA process. The network pharmacy may enter the designated override code provided and submit a claim for the 72-hour supply of medication. You don't need to call to request the emergency supply.

Emergency supplies are dispensed with no copay. If we approve the PA request, the pharmacy collects the copay when the balance of the prescription is filled.

Transition of care/continuity of care

If a member leaves another plan or regular Medicaid to join Healthy Blue, we'll cover the member's drugs needing approval for 90 days after the member joins Healthy Blue. Healthy Blue is required to honor existing prescriptions needing a prior authorization under the new Plan's formulary for up to 90 days. Please note, a member is only allowed a one-time fill for a 30-day supply during the transition period.

The first refill for a nonpreferred medication after the initial transition fill or following the identified transition period will reject per the Healthy Blue PDL. PA is required per policy.

Nonpreferred prescriptions

Healthy Blue encourages providers to prescribe preferred medications whenever medically appropriate. Access to nonpreferred medications requires submission of a PA request. PA requests may be submitted:

- By phone: 844-410-6890.
- By fax: 844-512-9005.
- Online: www.CoverMyMeds.com.

To get PA forms, visit www.HealthyBlueSC.com.

Prior to being dispensed, we must perform an internal review of nonpreferred medication PA requests. We may approve nonpreferred medications if there are documented treatment failures, intolerance, contraindications or adverse effects to available preferred medications.

Dose optimization

The Dose Optimization Program, or dose consolidation, is an extension of the Quantity Supply Program that helps increase patient adherence to drug therapies. This program works with the member, the pharmacist, and the member's physician or health care provider to replace multiple doses of lower-strength medications with a single dose of a higher-strength medication. This is done only when medically appropriate and with the prescribing physician's approval.

For a PA form for dose optimization, visit www.HealthyBlueSC.com.

Self-injectables

We cover FDA-approved injectable medications for self-administration through the outpatient prescription drug benefit. These medications, however, may be subject to written PA. If a medication requires PA, use of the following options to request it:

- Call the Prior Authorization of Benefits Call Center at 866-757-8286.
- Fax PA forms to the Prior Authorization of Benefits Call Center at 844-512-7027.
- Visit My Insurance Manager

To get a PA form and a list of drugs that require PA, visit www.HealthyBlueSC.com.

For a list of self-injectable medications, visit www.HealthyBlueSC.com.

PHARMACY CONTACTS

CarelonRx is the pharmacy benefit manager for Healthy Blue.

For answers to pharmacy benefit questions including eligibility, PDL status, and benefit exclusions or inclusions, contact the Pharmacy Help Desk at 833-253-4711.

BEHAVIORAL HEALTH (BH)

Healthy Blue covers BH services provided by licensed independent practitioners (LIPs), providers in the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) network, South Carolina Department of Mental Health (DMH) providers, South Carolina Department of Education (DOE) providers, and Healthy Blue Rehabilitative Behavioral Health Service (RBHS) providers.

Healthy Blue works directly with LIP, DAODAS, DMH, DOE and RBHS provider networks to get needed authorizations for our members who receive services.

Healthy Blue encourages providers to review the most current BH Clinical Practice Guidelines.

Healthy Blue distributes Clinical Practice Guidelines and Preventive Health Guidelines to contracted providers via the Healthy Blue website, www.HealthyBlueSC.com. Clinical Practice Guidelines are also available to members and potential members upon request. If you do not have internet access, contact Provider Service at 866-757-8286 for guidelines.

Healthy Blue uses the BH criteria in the chart when making medical necessity decisions.

Level of care	Criteria used
Inpatient acute psychiatric care (including IMD)	MCG Care Guidelines 27th edition 2021
Observation level of care	MCG Care Guidelines 27th edition 2021
Psychiatric residential treatment	MCG Care Guidelines 27th edition 2021
All services rendered by DAODAS	
Commissions with the exception of RBHS	American Society of Addiction Medicine (ASAM criteria)
RBHS	SCDHHS Rehabilitation Behavioral Health Service
Manual	
Autism services	Healthy Blue Care Guidelines
Outpatient care	MCG Care Guidelines 27th edition 2021
Vivitrol injections	MCG Care Guidelines 27th edition 2021
Psychological testing (psychological)	MCG Care Guidelines 27th edition 2021

Additional information about the care guidelines used for medical necessity determination are at www.HealthyBlueSC.com.

Healthy Blue uses medical necessity criteria for inpatient and outpatient mental health services. Healthy Blue uses the same ASAM medical necessity criteria as DAODAS for substance use services. For mental health and BH services only, providers can refer members directly to the LIP, the DAODAS, the DMH, the DOE and RBHS provider networks. Members can self-refer to a provider of their choice. If a member selects a provider outside of the Healthy Blue network, we may require a PA. For assistance in accessing BH care, members may contact Provider Service to find a BH provider. If a member needs subspecialty BH care (ECT therapy, RBHS), PA for these services may be required. Members may contact Member Service at 866-781-5094 to determine if their BH services require PA, or their BH provider may contact Provider Service at 866-757-8286.

TONSILLECTOMIES

Healthy Blue follows the Academy Otolaryngology Head and Neck Surgery Clinical Practice Guideline CG-SURG-30 for appropriate surgical tonsillectomy recommendations. This guideline is available for review at www.HealthyBlueSC.com.

TRANSPLANT SERVICES

Pre- and post-transplant services that Healthy Blue covers requires PA. The SCDHHS covers the transplant itself; therefore, the SCDHHS-contracted quality improvement organization (QIO), KePRO, must authorize all potential kidney transplants, cadavers or living donors before services are performed. The QIO reviews all referrals for organ transplants and issues an approval or denial.

If the SCDHHS approves the transplant, the approval letter serves as authorization for pre-transplant services (72 hours preadmission), the event (hospital admission through discharge) and post-transplant services up to 90 days from the date of discharge.

For information concerning transplant arrangements, call 866-757-8286.

VISION SERVICES

Through VSP, we cover one routine eye exam every 12 months for members. File claims directly to VSP. There is a $3.30 copay for vision services for members 19 years of age and older who see an optometrist or ophthalmologist (eye doctor) for medical reasons. The table below identifies VSP billable codes. Visit the VSP dedicated provider website (www.Eyefinity.com) for a full listing of the codes and description for services billable to VSP.

Type of service	Code
Exams and office visits	92002, 92004, 92012, 92014, 92015
Evaluation and management services	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Urgent/emergency care	99050, 99051, 99056, 99058
Special ophthalmological services	76510, 76511, 76512, 76513, 76514, 76516, 76519, 76529, 92020, 92025, 92060, 92070, 92081, 92082, 92083, 92100, 92120, 92130, 92135, 92136, 92140, 92225, 92226, 92230, 92235, 92250, 92260, 92265, 92270, 92275, 92283, 92284, 92285, 92286, 92287, 95930
Eye and ocular adnexa services	65205, 65210, 65220, 65222, 65430, 65435, 67820, 67840, 67938, 68020, 68040, 68761, 68801, 68810, 68815, 68840

For PA and information, call VSP at 800-615-1883.

SERVICES THE SCDHHS COVERS

Services covered by Healthy Blue and/or the SCDHHS through a fee-for-service or traditional coverage benefit are detailed below:

Dental services

The Healthy Connections adult dental service fee-for-service benefit is administered by DentaQuest. Adult dental services benefits include any covered diagnostic, preventive, therapeutic, rehabilitative, or corrective procedure. Providers must document medical necessity and any referral information in the member's medical record and include a detailed description of services rendered. Healthy Connections does not cover services rendered for cosmetic purposes.

Adult preventive dental benefit

Eligible Medicaid members ages 21 and older may receive up to $750 annually in covered dental treatment under the adult preventive dental benefit. The current benefit year runs from July 1–June 30. A $750 maximum benefit is based on claim payments under the Healthy Connections Adult Dental Fee Schedule.

Sedation is not included within the standard Healthy Connections benefit. When medically necessary, members with a special needs diagnosis or those receiving treatment by an oral surgeon may receive sedation services, which is excluded from the annual maximum benefit amount. Reimbursement for these services requires review for medical necessity. Submission of a claim for treatment under the adult preventive benefit does not require any special indication or documentation unless the use of sedation as medically necessary needs to be determined.

Adult members ages 21 and older may also receive emergency medical services by an oral surgeon and any dental services necessary to treat exceptional medical conditions. Neither treatment category consumes the $750 annual maximum under the adult preventive dental benefit if claims for treatment under these categories are appropriately submitted.

Child dental benefit

DentaQuest provides routine dental services for children under the age of 21. Claims for routine dental services must go to DentaQuest. Providers can submit anesthesia claims for emergency dental procedures to Healthy Blue.

For PA or other information, contact DentaQuest at 888-307-6552.

Hospice services

SCDHHS requires PA for Medicaid hospice services and medical record review prepayment from their QIO, KePRO.

If a member is assigned to a managed care organization (MCO) and has elected or been referred for hospice, the referring provider should contact KePRO for authorization. This member will be transferred back to fee-for-service Medicaid. MCOs will cover the member until the member can be transferred.

For Medicaid-only members, hospice services must be approved prior to the first requested day of service and before the submission of claims for Medicaid payment.

To complete the PA process, the following documentation must be submitted for review:

- KePRO Prior Authorization Hospice Request Form
- Medicaid Hospice Election Form (DHHS Form 149)
- Medicaid Hospice Physician Certification/ Recertification Form (SCDHHS Form 151)
- Hospice Plan of Care

Clinical information and other documentation supporting the medical prognosis and showing the degree of impairment.

ESSENTIAL PUBLIC HEALTH SERVICES

Healthy Blue collaborates with public health entities in all service areas to ensure essential public health services for members.

Services include:

- Ensuring appropriate public health reporting (communicable diseases and/or diseases that immunizations prevent).
- Notification and referral of communicable disease outbreaks involving members.
- Referral for tuberculosis and/or sexually transmitted diseases/HIV contact.
- Investigation, evaluation and preventive treatment of individuals with whom the member came into contact.
- Referral for women, infants and children services and information sharing.
- Coordination and follow-up of suspected or confirmed cases of childhood lead exposure.

Directly observed therapy (DOT) for tuberculosis (TB)

TB has reemerged as an important public health problem and drug resistance continues to increase. Poor compliance with medical regimens is a major reason for development of resistance. In DOT, patients are assisted in taking medications prescribed to treat TB.

Members can choose to receive TB services from any public health agency. If a member receives TB services outside of the Healthy Blue network, the SCDHHS covers these services.

Reportable diseases

A state mandate requires physicians and providers to report communicable diseases and conditions to local health departments within 24 hours of diagnosis. Our physicians and providers must comply with all state laws in the reporting of communicable diseases and conditions. Timely reporting is vital to minimize the incidence and prevalence of communicable diseases.

WOMEN, INFANTS AND CHILDREN (WIC) REFERRALS

Provider responsibilities include:

- Completing a WIC referral form or other form that documents:
  - Anthropometric data (height, current weight, pregravid weight).
  - Biochemical date (hemoglobin, hematocrit).
  - Expected date of delivery.
  - Any current medical conditions.
- Providing the member with a completed referral form to be presented at the local WIC agency.

Visit the state WIC website for more information.

INTERPRETER SERVICES

Interpreter services for members who are hearing and/or speech impaired are available at no cost to members. Providers must notify members of the availability of health plan interpreter services and discourage the use of minors, friends and family who may act as interpreters. Providers can find the Interpreter Services Desktop Reference at www.HealthyBlueSC.com. This document is useful when working with members to determine the language needed for interpreter services.

Services include:

- Telephone interpreters: Available by calling Provider Service at 866-757-8286 or the 24-Hour Nurseline at 800-830-1525 after-hours.
- Face-to-face interpreters: Call Provider Service 72 hours in advance to schedule services for key points of medical contact. We request 24 hours to cancel an interpreter service. To schedule by email, send the following to HBProviderService@healthybluesc.com.
  - Member ID number and name
  - Appointment date and time
  - Destination address
  - Doctor's name and phone number

For services for members with hearing loss, call Provider Service 72 hours in advance to schedule sign language interpreters for use at key points of medical contact. We request 24 hours to cancel an interpreter service. To schedule by email, send the following to HBProviderService@healthybluesc.com:

- Member ID number and name
- Appointment date and time
- Destination address
- Doctor's name and phone number

Members with vision loss can request verbal assistance or alternative formats of printed materials.

MEMBER ELIGIBILITY

ELIGIBILITY VERIFICATION

The SCDHHS determines eligibility and enrollment for members.

Healthy Blue electronically updates member eligibility following notification from the SCDHHS, or its eligibility agents, of changes in member eligibility.

Confirm member identity

To prevent fraud and abuse, providers should confirm the identity of the person presenting the Healthy Blue ID card. Claims for services rendered to noneligible members are not eligible for payment.

Ask to see ID cards

At each member visit and before rendering services, providers should ask to see the Healthy Blue Member ID card.

Forms of identification:

- Healthy Blue member ID card: This card contains the member's name and identification number, PCP name, the Provider Service phone number, and access information for the 24-Hour Nurse Line — a 24-hour health information line.
- Healthy Connections card: SCDHHS issues this identification card after approving the member's eligibility. Providers can swipe this card in a point-of-service device to verify eligibility or use the toll-free number on the card 866-757-8286 to call the Provider Service and access the Medicaid interactive voice response system.

Verify member eligibility

To verify member eligibility, log in to My Insurance Manager.

MEMBER ID CARDS

Sample Medicaid cards

After SCDHHS verification, the member receives a state-issued Healthy Connections (Medicaid) card. This card contains eligibility information. Swipe the card in a point-of-service device to access it. The Healthy Blue card contains the member's ID number as well as the payer ID number. Each time a provider sees a member, the provider should ask the member to present either his or her:

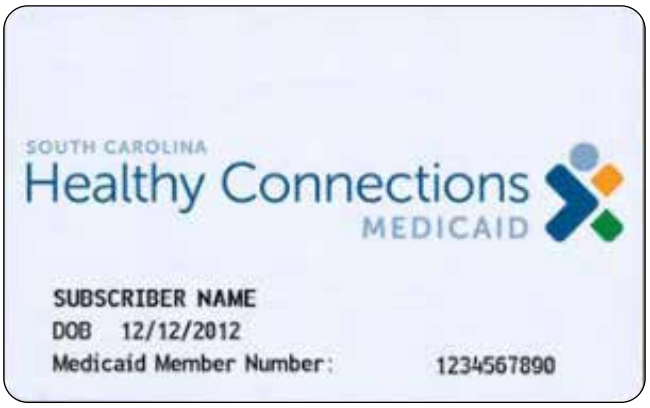
- Healthy Blue member ID card.
- Healthy Connections (Medicaid) card.

Healthy Blue sample member ID card

Front of card

Back of card

SCDHHS Healthy Connections sample member ID card



Front of card

Back of card

NONDISCRIMINATION

Healthy Blue does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to members. Healthy Blue does not use or administer criteria having the effect of discriminatory practices based on gender or gender identity. Healthy Blue does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of, or subjecting them to discrimination based on gender or gender identity.
In addition, in compliance with the Age Act, Healthy Blue does not discriminate against any person on the basis of age or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Healthy Blue provides health coverage to our members on a nondiscriminatory basis according to state and federal law regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Healthy Blue representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal: U.S. Department of Health & Human Services - Office for Civil Rights (hhs.gov)
- By mail: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone: 800-368-1019 (TTY/TTD: 800-537-7697)

Complaint forms are available at Filing with OCR | HHS.gov.

To communicate effectively with us, Healthy Blue provides no-cost tools and services to those with disabilities. Healthy Blue also provides no-cost language services to those whose primary language isn't English (for example, qualified interpreters and information written in other languages). Services can be obtained by calling the customer service number on the member's ID card.

If you or your patient believes that Healthy Blue has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, gender, or gender identity, you can file a grievance with our grievance coordinator via:

- Mail: Attn: Healthy Blue, P.O. Box 100317, Columbia, SC 29202-3317
- Phone: 866-781-5094

Equal program access on the basis of gender

Healthy Blue provides individuals with equal access to health programs and activities without discriminating based on gender. Healthy Blue must also treat individuals consistently with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with or association with a member of a protected class (i.e., race, color, national origin, gender, gender identity, age, or disability).

Healthy Blue does not deny or limit health services that are ordinarily or exclusively available to individuals of one gender to a transgender individual based on the fact that a different gender was assigned at birth or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

CLAIMS AND BILLING

INTRODUCTION AND GENERAL CLAIMS GUIDELINES

To achieve our goal of rapid and efficient claims payment, we need your help. Follow the guidelines below to ensure the claims submittal and payment process goes smoothly.

Share this section with your staff and, if applicable, with the appropriate billing service agent and electronic data processing service agent. It's important everyone involved understands the guidelines for preparing and submitting claims for services rendered to Healthy Blue members.

BILLS TO MEMBERS

In most cases, you should not send a bill to a member, but there are exceptions. You may send a bill to a member if:

- The member is responsible for a copay.
- The member agreed ahead of time, in writing, to pay for services that are not covered nor approved by Healthy Blue.
- The member agreed ahead of time, in writing, to pay for services from a nonparticipating provider. If that nonparticipating provider did not get approval from Healthy Blue ahead of time but they rendered services anyway, the member is responsible for the bill.

If you send a member a bill for reasons outside of the criteria above, call Provider Service and provide the date of service, type of service and amount you billed the member. Provider Service will evaluate the bill and let you know if a member will have to pay. As a provider, you may send members a "statement" that is not a "bill."

MAILING ADDRESS

Claims and correspondence mailing address:
Attn: Healthy Blue
PO Box 100317
Columbia, SC 29202-3317

THE IMPORTANCE OF A CLEAN CLAIM

Submit completed claims with all required fields in accordance with HIPAA requirements. Claims submitted as outlined in this chapter are called clean claims. A clean claim is error free, and we can process it without getting additional information from the provider or third party. We do not extend claim submittal time limits based on third-party liability requirements. We only consider clean claims received and entered into the claims processing system within one year from the date of service (or date of discharge for hospital claims) for payment. This section assists providers in understanding how to submit a claim correctly the first time, which helps to avoid delays in processing.

The one-year time limit does not apply to:

- Medicare cost sharing claims.
- Claims involving retroactive eligibility.

Healthy Blue no longer considers claims that exceed the timely filing limits due to the provider being unaware of a member's coverage.

Special note: The submission of a clean claim should not be misconstrued as being a proper claim for payment. Audits (pre- and post-payment) can occur by different departments for which a repayment may be requested. Providers are advised to follow proper coding practices using the current procedural and medical policies available. Providers may be requested to produce medical record documentation supporting the claim(s) to validate payment.

CLAIM INQUIRIES

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience Program helps you with claim inquiries. Just call 866-757-8286. We connect you with a dedicated resource team to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround times for inquiry resolution.
- Increased outreach to keep you informed of your inquiry status.

Provider Service can assist you in determining the appropriate process to follow for resolving your claim issue.

MCKESSON CLAIMSXTEN™

Healthy Blue uses claims editing software from McKesson, called ClaimsXten. ClaimsXten incorporates the McKesson editing rules that determine whether a claim should be paid, rejected or requires manual processing. McKesson is an independent company that makes software that helps Healthy Blue edit claims.

These editing rules assess Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes on the CMS-1500 form. A claim auditing action then determines how the procedure codes and code combinations are adjudicated. The auditing action recognizes historical claims related to current submissions and may result in adjustments to previously processed claims. You can find descriptions of specific reimbursement policies in this manual.

ClaimsXten is updated periodically. Healthy Blue notifies providers of these updates in advance as per your Provider Agreement.

CLAIMS FILING

Initial claims filing

Healthy Blue accepts claims from all providers up to 365 days after the date of service.

Claims returned via mail for additional information

Claims returned via mail for additional information are not noted as received in our claims system. Providers have 365 days from the date of service to refile the claim electronically through My Insurance Manager or by mail. You can submit original paper claims by mail to:

Attn: Healthy Blue
PO Box 100317
Columbia, SC 29202-3317

Claims neding additional information

Providers must resubmit claims originally rejected for missing or invalid data elements within 365 calendar days from the date of service to the correspondence mailing address listed:

Attn: Healthy Blue
PO Box 100317
Columbia, SC 29202-3317

Corrected claims

Providers must resubmit previously denied claims with corrections and requests for adjustments within 365 calendar days from the date of service. The claim must be clearly marked as a “corrected claim” and include the original claim number, so we do not deny the claim as a duplicate or for exceeding the timely filing limit.

Providers can submit claims with requested additional information, claims to be reconsidered, corrected claims and other general correspondence about claims, including any supporting documentation, to:

Attn: Healthy Blue
PO Box 100317
Columbia, SC 29202-3317
CLAIM PAYMENT DISPUTES

Provider claim payment dispute process

If you disagree with the outcome of a claim, you may begin the provider payment dispute process.

There are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- Claim inquiry: a question about a claim but not a request to change a claim payment
- Claims correspondence: when Healthy Blue requests further information to finalize a claim; typically includes medical records, itemized bills or information about other insurance a member may have
- Medical necessity appeals: a preservice appeal for a denied service in which a claim has not yet been submitted

Providers are not penalized for filing a claim payment dispute, and no action is required by the member.

A claim payment reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.

For timely filing issues, we consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can either:

- Provide documentation the claim was submitted within the timely filing requirements.
- Demonstrate good cause exists.

CLAIM PAYMENT RECONSIDERATION

The only step in the claim payment dispute process is called reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our secure provider website within 90 calendar days of the date on the Explanation of Payment. Reconsiderations filed more than 90 days from the Explanation of Payment are considered untimely and denied unless good cause can be established.

When submitting reconsiderations, include as much information as you can to help us understand why you think the claim was not paid as you would expect.

HOW TO SUBMIT A CLAIM PAYMENT DISPUTE

Healthy Blue has dedicated Provider Relations staff who are available via phone, email, mail and in person to answer questions, file provider disputes and resolve problems.

- Verbally: Call the Provider Service at 866-757-8286.
- Written: Mail all required documentation (see below for more details), including the Reconsideration Form to:

Attn: Healthy Blue
P.O. Box 100317
Columbia, SC 29202-3317

REQUIRED DOCUMENTATION FOR CLAIMS PAYMENT DISPUTES

Healthy Blue requires the following information when submitting a claim payment dispute:

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and Healthy Blue Medicaid ID number
- A listing of disputed claims, including the Healthy Blue claim number and the date(s) of service(s)
- All supporting statements and documentation

CLAIM CORRESPONDENCE

Claim correspondence is different from a payment dispute. Correspondence is when Healthy Blue requires more information to finalize a claim. Typically, Healthy Blue asks for this information through the Explanation of Payment (EOP). The claim or part of the claim may be denied, but it is only because more information is required to process the claim. Once the information is received, Healthy Blue uses it to finalize the claim.

The table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of issue	What do I need to do?
Electronic rejected claim(s)	If your claim was never paid or was rejected, review your reports from either your vendor or My Insurance Manager so you can correct for resubmission.
EOP request for supporting documentation (sterilization, hysterectomy or abortion consent forms, itemized bills and invoices, etc.)	Submit a Claim Correspondence Form, a copy of your EOP and supporting documentation to: Attn: Healthy Blue PO Box 100317 Columbia, SC 29202-3317
EOP request for medical records	Submit a Claim Correspondence Form, a copy of your EOP and medical records to: Attn: Healthy Blue PO Box 100317 Columbia, SC 29202-3317
Submission of Coordination of Benefits (COB)/third-party liability (TPL) information	Submit a Claim Correspondence Form, a copy of your EOP and COB/TPL information to: Attn: Healthy Blue PO Box 100317 Columbia, SC 29202-3317

CLAIM FORMS

Generally, there are two types of forms used for submitting claims for reimbursement:

CMS-1500 Claim Form — for professional services

CMS-1450 (UB-04) Claim Form — for institutional services

CLAIM FILING LIMITS

Healthy Blue requires all claims to be submitted within the contracted filing limit to be considered for payment.

Healthy Blue denies claims received after the filing limit. Refer to your provider agreement for claim filing and processing time frames.

CLAIMS EDITS

An edit is a practice or procedure when one or more adjustments are made to CPT codes or HCPCS Level II codes included in a claim that results in:

- Basing payment on some, but not all, of the CPT codes or HCPCS Level II codes included in the claim.
- Basing payment upon different CPT codes or HCPCS Level II codes than those included in the claim.
- Reducing payment for one or more of the

- CPT codes or HCPCS Level II codes included in the claim by application of multiple procedure logic.
- Denying payment for one or more of the CPT codes or HCPCS Level II codes.
- Any combination of these.

Incidental procedures

An incidental procedure is performed at the same time as a primary procedure, and payment is considered inclusive with the primary procedure. Codes are considered incidental if billed separately or in combination with other codes. We always deny incidental procedures.

Significant edits

A significant edit is an edit that, based on experience with submitted claims, causes the denial or reduction in payment (on initial review of the submitted claim) for a particular CPT code or HCPCS Level II code submitted more than 250 times per year.

Note: Inclusion of an edit code in the table below does not imply or guarantee coverage. Reimbursement policies and processing edits evolve over time. Healthy Blue reserves the right to review and update them periodically. Additionally, the state mandates many claim processing edits and requirements for Medicaid programs, so they are subject to change.

Significant edit listing

Significant edit listings are based on review of historical claims data for claims processed and is based on CPT and HCPCS codes in effect at the time. The data reflects the edit logic in place at the time we processed the claims. For Healthy Blue, significant incidental edits are outlined below.

CPT code	Description
Modifier 25 — This denies when billed with modifier 25:	
T1015	Clinic visit/encounter, all-inclusive
Evaluation and management (E&M) — These deny when billed with E&M codes 99201 – 99394:	
93010	Electrocardiogram (ECG), routine ECG with at least 12 leads, interpretation and report only
CPT code	Description
Surgical codes — These deny when billed with surgical codes 10,000 – 60,000:	
99070	Physician-provided supplies and materials, except spectacles, over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies or materials provided)
A4550	Surgical trays
99211 – 99215	Office or other outpatient visit for the E&M of an established patient
94760	Noninvasive ear or pulse oximetry for oxygen saturation, single determination
This denies when billed with surgical code 54150:	
64450	Injection, anesthetic agent; other peripheral nerve or branch

NATIONAL DRUG CODES

Healthy Blue requires national drug codes (NDCs), unit of measurement and quantity of unit when submitting claims for drugs dispensed in both professional (medical) and institutional (facility) outpatient settings.

Healthy Blue is required to report NDC data each month to the South Carolina Department of Health and Human Services, who forwards this utilization data to pharmaceutical manufacturers to get rebates under the Medicaid Drug Rebate Program. It is important to follow our instructions when submitting claims to ensure the state receives timely Medicaid drug rebates from drug manufacturers.

Billing for outpatient drugs using NDCs

Please note, N4 must be entered before the NDC on claims.

The NDC is an 11-digit number on the package or container from which medication is administered.

NDC number section	Description
1 (five digits)	Vendor/distributor identification
2 (four digits)	Generic entity, strength and dosage information
3 (two digits)	Package code indicating the package size

Unit of measurement requirements

You must submit unit of measurement codes. Use the following codes for all claim forms:

- F2 — international unit
- GR — gram
- ML — milliliter
- UN — unit

Using NDCs when submitting claims

Depending on the claim type, you must submit the NDC information as indicated for paper claims or the equivalent electronic field.

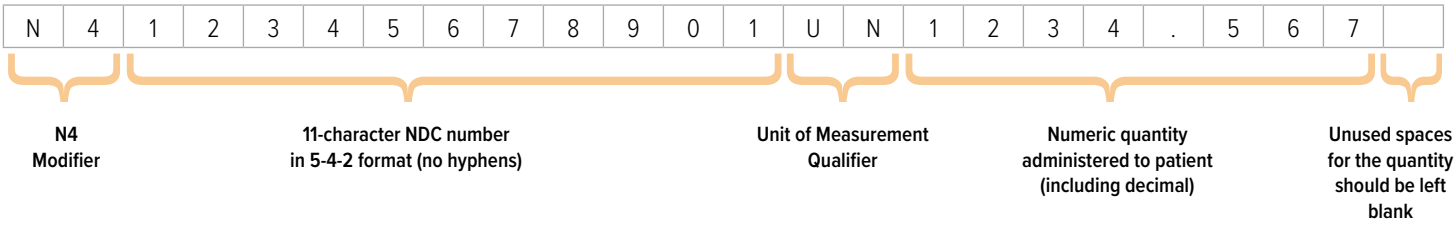
Proper coding of NDCs with fewer than 11 digits

Convert NDCs with fewer than 11 digits to an 11-digit number for proper claims submittal. The table below illustrates the proper method to use for conversion.

Use leading zeroes when billing. The correctly formatted, additional “0” is in a bold font and underlined in the example.

Proper conversion of NDCs from 10 digits to 11 digits					
10-digit format on package	10-digit format example	11-digit format	11-digit format example	10-digit NDC example	11-digit conversion example
4-4-2	9999-9999-99	5-4-2	09999999999	0002-7597-01 Zyprexa® 10 mg vial	00002759701
5-3-2	99999-999-99	5-4-2	99999099999	50242-040-62 Xolair® 150 mg vial	50242004062
5-4-1	99999-9999-9	5-4-2	99999999909	60575-4112-1 Synagis® 50 mg vial	60575411201

Note: While NDCs are formatted on drug packaging using hyphens to separate the components, do not use hyphens when entering NDCs on claim forms.



Process for multiple NDC numbers for single HCPCS codes

If there is more than one NDC within the HCPCS code, submit each applicable NDC code as a separate claim line. Each drug code you submit must have a corresponding NDC on each claim line.

If the drug administered has more than one ingredient (compound or same drug with different strength, etc.), represent each NDC on a claim line using the same drug code.

Standard HCPCS billing accepts the use of modifiers to determine when more than one NDC is billed for a service code. They are:

- KP — first drug of a multiple drug unit dose formulation.
- KQ — second or subsequent drug of a multiple drug unit dose formulation.
- SH — second or concurrently administered infusion therapy.
- SJ — third or more concurrently administered infusion therapy.

OTHER FILING LIMITS, CHECKING CLAIM STATUS AND MAIL-BACK FORMS

Action	Description
Claims for retroactive eligibility	Claims involving retroactive eligibility must meet both of the listed criteria for us to consider payment: Received and entered into the claims processing system within six months of the member's date of eligibility Received within three years of the date of service or date of discharge (for hospital claims) Claims involving retroactive eligibility that we receive more than three years from the date of service are rejected. Providers are responsible for submitting one of the following with each claim, within the listed time frames, to document retroactive eligibility: DHHS Form 945 — a statement verifying retroactive determination of eligibility Computer-generated Medicaid eligibility approval letter notifying the member that Medicaid benefits have been approved, furnished by the member or by the eligibility worker (This is different from the certificate of creditable coverage.)
Checking claim status	You can check the status of a claim anytime by logging in to My Insurance Manager.
Claim follow-up request mail-back form	This is used to submit a corrected claim following a request for more information or a correction to a claim or to follow up on a claim.

QUESTIONS ABOUT CLAIMS

For questions about claims, including completing the forms, use My Insurance Manager or call Provider Service at 866-757-8286.

SUBMITTING A CLAIM

Methods for submitting claims:

- EDI via your clearinghouse
- My Insurance Manager
- Paper or hard copy

Include the following elements on all claims:

- Federal nine-digit tax ID number
- Billing NPI, name and address
- Rendering NPI, name and address
- Taxonomy code

ZCD prefix for accurate claim processing

Always use the member's ID with the three-byte alpha-prefix ZCD when filing claims. This prefix is necessary to route the claim to the right location for prompt processing. If you omit the ZCD, the claim may go to the wrong location and cause payment delay, or it may never reach the right location and result in nonpayment.

The alpha prefix plus the member's ID is 13 bytes long. The ID consists of the three alpha characters ZCD and the 10-digit Medicaid ID number.

Electronic claims

Submit claims electronically through an approved electronic billing system software vendor or clearinghouse. Completion of electronic claim submission requirements can speed claim processing and prevent delays.

To use electronic data interchange (EDI), include the following:

- Billing provider's name and practice name
- Legal name
- Billing NPI number
- Federal provider nine-digit tax ID number
- Member Medicaid ID number (ZCD + 10-digit Medicaid ID number)
- Payer ID number 00403 (The Medicaid payer ID is not the same as the commercial payer ID.)

- Last menstrual period (if applicable)
- Birth weight (if applicable)
- Rendering NPI number
- Taxonomy code

After submitting electronic claims:

- Watch for and confirm batch status reports, which you can correct and resubmit electronically from the vendor/clearinghouse to ensure the claims were accepted.
- Correct any errors and resubmit immediately to prevent denials due to untimely filing.
- A front-end edit process (for example, non-HIPAA-compliant transaction code sets) may occur at the contracted vendor or clearinghouse. If the claims error out, an error report is sent to the provider and the claim never reaches our EDI.

Using a clearinghouse eliminates the need to use multiple billing systems. Note, clearinghouses are connected with numerous vendors who may not be on the Healthy Blue vendor list. To receive a copy of the vendor list, call Provider Service at 866-757-8286.

Electronic data transfers and claims are HIPAA-compliant and meet federal requirements for EDI transactions, code sets, member confidentiality and privacy.

Paper claims

Healthy Blue scans paper claims for optimal processing and recording of data provided. Therefore, paper claims need to be legible and in the appropriate format to ensure scanning capabilities.

Providers are required to file paper claims using NPIs in lieu of legacy IDs (for example, a Medicare ID, Medicaid ID or license number) for consistency in claims filing.

On the CMS-1450 (UB-04) form, enter the facility NPI in box 56.

On the CMS-1500 form, enter the rendering provider NPI in box 24J, the service facility NPI in box 32A and the billing provider NPI in box 33A.

In addition, Healthy Blue requires the provider's nine-digit federal tax ID in box 25 on the CMS-1500 form and in box 5 on the CMS-1450 form.

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI is a 10-digit, all numeric identifiers. NPIs are issued to providers of medical and health services and supplies. NPI is one provision of the administrative simplification portion of HIPAA. NPI improves the efficiency of the health care system and reduces fraud and abuse.

SPLIT CLAIMS

Contracts can change during treatment. When a provider's reimbursement is affected by a contract change during a course of treatment, providers are required to split the dates of service to be covered at the new rate.

COORDINATION OF BENEFITS (COB)

When applicable, Healthy Blue coordinates benefits with other carriers or programs the member may have for coverage. Indicate other coverage information on the appropriate claim form. If the member has other health insurance, file claims with the other carriers and programs before filing with Medicaid.

If there is a need to coordinate benefits, include at least one of the following items from the other carrier or program when submitting a COB claim:

- Third-party remittance advice (RA)
- Third-party letter explaining the denial of coverage or reimbursement

We mail back COB claims received without the items noted above with a request to submit to the other carrier or program first. Please make sure the information submitted explains any coding listed on the other carrier RA or letter. Healthy Blue cannot process claims without this specific information.

When submitting COB claims, specify the other coverage in:

- Boxes 9a – 9dd of the CMS-1500 claim form.
- Boxes 58 – 62 of the CMS-1450 (UB-04) claim form.

THIRD-PARTY RECOVERY

Providers cannot interfere with or place any liens on the SCDHHS' right, or our right to act as an SCDHHS agent, to recover from third-party billing.

Note: Healthy Blue is not responsible for a member's copay from COB.

CLAIMS PROCESSING

Claim returned for additional information

A claim that is returned to a provider for correction or additional information is called a mail-back. If the provider does not resubmit within the designated time frame, we deny the claim.

Claim filing with wrong plan

If the provider files a claim with the wrong insurance carrier and provides documentation verifying the initial timely claims, Healthy Blue will process the claim without denying it for failure to file within filing time limits.

CLAIMS PAYMENT

Upon receiving claims, the claim is analyzed for covered services. Then an RA is generated that summarizes the services rendered and payer action taken, and the appropriate amount is sent to the provider. If payment is not warranted to the provider, a Claims Disposition Notice (CDN) is sent to the provider with the specific claims processing information.

Why submit claims electronically?

- Electronic claims are not subject to postal delays.
- Claims may be transmitted 24/7.
- Electronic claims are faster and more accurate.
- Electronic claims are acknowledged by Healthy Blue through notification and error reports that are placed in your electronic mailbox.
- Electronic remittance advices (ERAs) are offered to all electronic submitters. This provides a cost savings and allows the provider to post payments automatically.

EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Using your existing clearinghouse or billing vendor

EDI Payer ID

The payer ID is 00403.

For more information on EDI and how to register for My Remit Manager, email **EDI.Services@bcbssc.com**. My Remit Manager offers electronic remittance advices (835). The 835 eliminates the need for paper remittance reconciliation

Electronic funds transfer (EFT)

Electronic claims payment through EFT is a secure way to receive payment reducing administrative processes the fastest. EFT deposit is assigned a trace number that is matched to the 835 ERA for simple payment reconciliation.

Visit www.HealthyBlueSC.com for more information or to enroll. Electronic data transfers and claims are HIPAA-compliant and meet federal requirements for EDI transactions, code sets, member confidentiality and privacy.

Claims overpayment recovery procedure

Healthy Blue seeks recovery of all excess claim payments from the payee to whom the benefit check is made payable. When an overpayment is discovered, the overpayment recovery process is initiated by sending written notification of the overpayment to a physician, hospital, facility, or other health care professional (provider).

The cost containment/overpayment recovery contact number is 866-757-8286.

If the provider is notified of an overpayment or if the provider discovers that he or she has been overpaid, the provider needs to return the overpayment.

Mail a check and a copy of the overpayment to:

Attn: Healthy Blue
PO Box 100317
Columbia, SC 29202-3317

If providers believe the overpayment was created in error, they should contact Healthy Blue in writing. For a claims reevaluation, send correspondence to the address indicated on the overpayment notification.

If Healthy Blue does not hear from the provider or receive payment within 30 days, we deduct the overpayment amount from future claim payments. For providers with EDI, the overpayment recovery may be reflected in the ERA.

In cases where we determine that recovery is not feasible, we refer the overpayment to a collection service.

CLAIM STATUS INQUIRY AND FOLLOW-UP

Claim status online

Providers can confirm receipt of their claims by logging in to My Insurance Manager.

Claim follow-up/resubmission

If there has been no response to a submitted claim after 30 business days from the date the claim was submitted, providers can initiate follow-up action to determine the claim status.

To follow-up on a claim, check My Insurance Manager or contact Provider Service at 866-757-8286.

INTERACTIVE VOICE RESPONSE (IVR)

Our IVR system has been enhanced to make accessing member information, including eligibility and claim status, even easier for all providers. When asked to enter provider identification information, you can now use either your billing NPI number or federal TIN.

To access our IVR system, call Provider Service at 866-757-8286 at any time. When prompted, press 1 or say "English" to continue in English. Next, press 2 or say "provider" to access our provider menu. When prompted, enter the provider ID number using the telephone keypad or say the 10-digit billing NPI number or nine-digit federal TIN to continue.

Note: Should the system not accept your billing NPI or TIN, your call will be routed to a Provider Service representative who will help with the query.

You will then be asked to say the member's Healthy Blue ID number, which may include numbers and alpha characters. You can find the member's ID number on his or her Healthy Blue ID card.

Next, select one of these five options from the main menu:

- Fax-back information
- Eligibility information
- Coverage information
- Claims information
- Treatment authorization

BILLING PROFESSIONAL & ANCILLARY CLAIMS

This section describes billing guidelines for professional and ancillary claims.

CMS-1500 CLAIM FORM

Who should use a CMS-1500 claim form?

All professional providers and vendors should bill Healthy Blue using the most current version of the CMS-1500 form.

Completing a CMS-1500 claim form

Complete all the fields for reimbursement. See the Required fields for Filing a Medicaid claim on a CMS-1500 Form section for complete instructions.

NPI AND PRESCRIPTION DRUGS

We know all providers are accustomed to receiving the highest level of service and support from our plan and its staff. It is our continuing goal to ensure our members and the network providers who serve them have access to all the benefits and timely assistance we guaranteed.

NPI

We deny claims with missing NPI numbers. Providers are required to include the rendering provider's NPI number when submitting claims. This rendering NPI number should be in field 24J of the HCFA 1500 claim form.

Prescription drugs

We encourage providers to refer to the Healthy Blue PDL for a list of our preferred drugs. Drugs that are on the PDL that have a PA requirement are noted on the PDL. To view the PDL, go to www.HealthyBlueSC.com.

If a member leaves another Plan or regular Medicaid to join Healthy Blue, we'll cover the member's drugs needing approval for 90 days after the member joins Healthy Blue. Healthy Blue is required to honor existing prescriptions needing a PA under the new Plan's formulary for a period up to 90 days. Please note, a member is only allowed a one-time fill for a 30-day supply during the transition period.

Limits:

- Substances that are not controlled are limited to a 31-day supply.
- Select drugs in four categories may be eligible for an extended-day/90-day supply: asthma, cholesterol, oral diabetes and hypertension.
- We do not cover diet aids, cosmetics or hair growth drugs.
- We do not cover drugs for erectile dysfunction.
- The only over-the-counter drugs we allow are those on our PDL.
- The pharmacy benefit covers syringes and needles that a member uses to inject themselves with medicines at home, like insulin. The medical benefit, not their pharmacy benefit, covers syringes or needles that they don't use to inject themselves with medicine at home.
- The medical benefit covers injections that a PCP must give to a member (office-based injections), not their pharmacy benefits, with the exception of certain medications including but not limited to injectable antipsychotic medications that should be filled at an in-network pharmacy.

The pharmacy benefit covers the following diabetic supplies:

- Blood glucose monitors, including continuous blood glucose monitors
- Test strips
- Lancing devices
- Urine glucose testing strips

There are no limits on the number of prescriptions, but some medications may require PA.

PAPER CLAIMS

When Healthy Blue receives a high volume of paper claims submitted to the incorrect address, this causes delays in payment. The most efficient method of claims submission is electronic. The payer ID number for Healthy Blue is 00403. If providers have the capability to submit electronically, they should contact vendors to set up electronic claims submission. If this is not an option at this time, verify the correct claims submission address is on file:

Attn: Healthy Blue
PO Box 100317
Columbia, SC 29202-3317

Billing for rendering providers

Rendering providers need to supply their nine-digit federal tax ID and NPI numbers when filing claims. Indicate the rendering provider's NPI in box 24J of the CMS-1500 form. We require providers to always file the rendering provider ID.

Coding — professional

To be sure claims are processed in an orderly and consistent manner, standardized code sets are used. The HCPCS provides codes for billing a variety of services. These codes are sometimes called national codes. HCPCS consists of two principal subsystems, referred to as Level 1 and Level 2.

Level 1 consists of CPT codes the American Medical Association (AMA) maintains. CPT codes have five numeric digits.

Level 2 consists of other codes that identify products, supplies and services not included in the CPT codes, such as ambulances and durable medical equipment. These are sometimes called the alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character **modifier codes** should accompany the Level 1 or Level 2 coding.

Note: Per the SCDHHS, providers can only bill six lines on professional claims.

To ensure accurate handling and prompt payment of claims, use these national guidelines when coding claims:

- **CPT codes:** Refer to the current edition of the physicians' CPT manual published by the AMA. To order, call 800-621-8335.
- **HCPCS:** Refer to the current edition of HCPCS published by CMS. To order, call 800-621-8335.
- **Modifier codes:** Use modifier codes when appropriate with the corresponding HCPCS or CPT codes. For paper claims, all modifiers should be billed immediately following the procedure code in box 24D of the CMS-1500 Claim Form.

Selected code tables are provided as an attachment to assist providers with commonly used codes for professional services.

Please ensure the following elements are included on each claim:

- Nine-digit federal tax ID number
- Billing NPI, name and address
- Taxonomy code

Healthy Blue requires providers to file paper claims using their NPI in lieu of the legacy ID for consistency in claims filing. On the CMS-1500 form, enter the rendering provider NPI in box 24J, the service facility NPI in box 32A and the billing provider NPI in box 33A.

See the Required Fields for Filing a Medicaid Claim on a CMS-1500 Form section or field descriptions for the CMS-1500 claim form or visit the CMS website.

On-call services

When the rendering physician is not the PCP but is covering for or has received permission from the PCP to provide services that day, insert "on-call" for PCP in box 23 of the CMS-1500 form.

Member ID number

Use the Member's Healthy Blue ID card number on all claims you submit, not the number on the Medicaid ID card. Always file the member's ID with the three-byte alpha-prefix ZCD when filing claims.

INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION (ICD-10) DESCRIPTION

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services.

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9) that was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the U.S.

ICD-10-CM replaces the code sets ICD-9-CM volumes one and two for diagnosis coding. ICD-10 PCS replaces ICD-9-CM volume three for inpatient hospital procedure coding.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHC)

CPT codes are required when claims billing for RHCs and FQHCs. The requirement when using the CMS-1500 claim form is as follows:

When filing encounter codes

Box 33A	RHC or FQHC group NPI
24J	RHC or FQHC group NPI

RHCs

RHCs should file lab, nonclinical services and diagnostic codes with modifier TC and bill the above codes separately under the practitioner's NPI.

FQHCs

FQHCs must file nonclinical services with modifier TC and bill the above codes separately under the practitioner's NPI.

Box 33A	RHC or FQHC group NPI
24J	Rendering provider's NPI

REQUIRED FIELDS FOR FILING A MEDICAID CLAIM ON A CMS-1500 FORM

When filing a paper claim for professional claims, please use the August 2005 CMS-1500 paper claims form. For examples or explanations of the fields, refer to the Physicians Services Provider Manual and Hospital Services Manual.

When filing a professional claim for Healthy Blue services, the following fields are required for a correctly completed clean claim submission.

CMS-1500 field number	Description
1a	Insured's ID number: Enter the member's plan ID, including the alpha-prefix ZCD followed by the member's 10-digit ID number. Do not enter the number on the Medicaid ID card the state issues.
2	Patient's name
3	Patient's date of birth, sex
4	Insured's name
5	Patient's address (street, city, state, ZIP code)
6	Patient relationship to insured
7	Insured's address (street, city, state, ZIP code)
8	Patient status
12	Signature
17	Name of referring physician (if applicable)
17b	NPI — referring physician (if applicable)
21	Diagnosis code
23	PA number (if applicable)
24a	Date of service — from/to
24b	Place of service
24d	CPT/HCPCS and/or modifier
24e	Diagnosis pointer: Follow directions on the claim form. (See box 21 for more information.)
24f	Charges

CMS-1500 field number	Description
24g	Days or units
24h	EPSDT: Include EPSDT referral with Y or N. (Do not leave blank.)
24i	Provider ID qualifier: ZZ for taxonomy and/or NPI
24j	In the shaded field, enter the rendering provider's taxonomy code and in the unshaded field, enter the NPI.
25	Federal nine-digit tax ID number
28	Total charges
31	Signature of physician
32	Service facility location information
32a	Service facility NPI
32b	Provider ID qualifier: ZZ for taxonomy
33	Billing provider information
33a	Billing NPI
33b	Provider ID qualifier: ZZ for taxonomy

If there is a coordination of benefits, please attach the primary insurance proof of coverage (provider remittance advice showing the primary payment).

PROFESSIONAL BILLING REQUIREMENTS BY SERVICE CATEGORY

Behavioral health

Healthy Blue covers mental health assessment services provided in the office or in the ER as well as hospital inpatient and related professional services. We also cover other behavioral health and substance use services licensed independent practitioners, rehabilitative behavioral health service providers and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) commissions provide.

Anesthesia Claims

Follow these guidelines when billing anesthesia claims.

Paper submissions

Providers who submit paper claims should:

- Use the appropriate American Society of Anesthesiologists (ASA) CPT anesthesia code (00100 – 01999) with the appropriate modifier.
- Indicate the actual time of the service rendered, in minutes, in field 24G of the CMS-1500 form.

Do not report the base units on claims.

Electronic submissions

Providers who submit claims via EDI should:

- Use the appropriate ASA CPT anesthesia code (00100 – 01999) with the appropriate modifier.
- Indicate the actual time of the service rendered, in minutes, in the 465A record segment using an MJ qualifier (MJ qualifier within the electronic claim record = minutes billed).

Emergency services

We do not require authorizations for medically necessary emergency services. We define emergency services in Healthy Blue provider contracts, by state and local law, and in the member's EOC.

We cover related professional services physicians offer during an ER visit according to the provider's Healthy Blue provider contract.

For professional emergency services billing, indicate the injury date in box 14 on the CMS-1500 claim form if applicable.

All members should be referred to the PCP of record for follow-up care. Unless clinically required, follow-up care should never occur in the ER of a hospital.

Healthy Blue covers claims when emergency medical treatment is necessary. The ER treating physician determines whether services are necessary to stabilize the member's emergency medical condition.

Initial health assessments (IHAs)

Billing codes	
ICD-10 diagnosis codes: Z00129, Z00121 for newborn – 17 years of age Z008 for 17 years and over	CPT-4 diagnosis codes: 99381— preventive visit, age 0 – 1l 99382 — preventive visit, age 1 – 4 99383 — preventive visit, age 5 – 11 99384 — preventive visit, age 0 – 17 99385 — preventive visit, age 18 – 39 99386 — preventive visit, age 40 – 64 99387 — preventive visit, age 65 or older

Early and periodic screening, diagnosis and treatment (EPSDT) services

Billing codes	
When billing for EPSDT services, you must use these codes to document the receipt of an initial or periodic screening:	
CPT-4 diagnosis codes: preventive medicine services: 99381 — new patient under 1 year 99382 — new patient (age 1 – 4 years) 99383 — new patient (age 5 – 11 years) 99384 — new patient (age 0 – 17 years) 99385 — new patient (age 18 – 39 years) 99391 — established patient under 1 year 99392 — established patient (age 1 – 4 years) 99393 — established patient (age 5 – 11 years) 99394 — established patient (age 12 – 17 years) 99395 — established patient (age 18 – 39 years)	CPT-4 diagnosis codes: E&M codes: 99201 – 99205 — new patient 99211 – 99215 — established patient

Preventive medicine services

Billing codes	
ICD-10 diagnosis codes: Z00129 for newborns – 17 years of age Z0001 and Z01411 – Z008 for 17 years and older	CPT-4 diagnosis codes: 99384 — preventive visit, age 0 – 17 99385 — preventive visit, age 18 – 39 99386 — preventive visit, age 40 – 64 99387 — preventive visit, age 65 or older

Note: Healthy Blue follows the U.S. Preventive Task Force Guidelines schedule for wellness exams for members ages 21 and older.

Maternity services

Healthy Blue requires itemization of maternity services when submitting claims for reimbursement. Please use the appropriate CPT or HCPCS codes and ICD-10-CM diagnosis codes when billing and bill each as primary. This includes the applicable evaluation and management (E&M) code along with coding for all other procedures performed. Bill delivery charges with appropriate CPT codes. Refer to the list for maternity services codes (59409, 59612, 59514 and 59620).

Three ultrasounds are allowed before a PA is required. If requesting authorization for another ultrasound after three using the Request for Prior Authorization form, indicate on the form that the member has already had three ultrasounds.

If there are multiple births (all vaginal or all cesarean), bill the first birth with no modifier and bill each consecutive birth with modifier 51. If the multiple births are a combination (for example, first vaginal, second cesarean), bill the first birth with no modifier and bill the second (cesarean) with modifier 79.

Include operative notes with claims for multiple births of more than two:

- We cover antepartum care and deliveries, including cesarean sections that physicians perform and postpartum care.
- When billing, providers should itemize each service individually and submit claims as the services are rendered. We will apply the filing deadline to each individual date of service submitted.

- Providers should itemize laboratory (including pregnancy test) and radiology services provided during pregnancy in accordance with the provider's contract.

Use the CMS-1500 claim form with itemized E&M codes.

Early birth modifiers

Please append these modifiers when scheduling an induction of labor or planned cesarean sections for deliveries at less than 39 weeks gestation. Append the modifiers listed to all CPT codes when billing for vaginal deliveries and cesarean sections:

- **GB** — 39 weeks gestation and/or more

For all deliveries at 39 weeks' gestation or more regardless of method (induction, cesarean section or spontaneous labor):

- **CG** — less than 39 weeks' gestation

For deliveries resulting from patients presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks

For inductions or cesarean sections that meet the American College of Obstetricians and Gynecologists (ACOG) or approved Birth Outcome Initiative medically necessary guidelines (Be sure to complete and maintain the appropriate ACOG Patient Safety Checklist for documentation in the patient's file.)

For inductions or cesarean sections that do not meet the ACOG or approved Birth Outcome Initiative guidelines (Be sure to complete the appropriate ACOG Patient Safety Checklist and get approval from the regional perinatal center's maternal fetal medicine physician. The approval and the checklist must be documented in the patient's file.)

- No modifier — elective nonmedically necessary deliveries less than 39 weeks gestation

For deliveries less than 39 weeks gestation that do not meet ACOG or approved Birth Outcome Initiative guidelines or are not approved by the designated regional perinatal center's maternal fetal medicine physician

To access the ACOG Patient Safety Checklist and the approved Birth Outcome Initiative Approved Delivery Guidelines on the SCDHHS website, please follow these steps:

- Go to www.scdhhs.gov/provider-manual-list.
- Scroll down and select **Physicians Services Provider Manual** and **Hospital Services Manual**.
- Choose **Download Entire Manual**.
- Go to pages 510 – 515 for the Birth Outcome Initiative Approved Delivery Guidelines.
- Go to pages 520 – 523 for the ACOG Patient Safety Checklist.

Global codes

Global codes cannot be used for billing. If we receive a claim with global coding, we will reject the claim.

Newborns

The SCDHHS enrolls newborns into the same managed care plan as the mother.

Newborn hearing screenings are included in the core benefits when they are rendered to newborns in an inpatient hospital setting. This procedure is not included in the diagnostic-related grouping rates, and you should bill it separately.

Newborns are the responsibility of the mother's managed care plan unless the mother has specified otherwise. The newborn's effective date is the first day of the month of birth. The Newborn Enrollment Notification Report contains a statement that the member understands we will enroll a child born into the family unit in the same managed care plan as the mother unless the mother otherwise specifies before the birth.

Do not bill for newborn services under the mother's Medicaid number. We require providers to wait until they receive the newborn's Medicaid number to bill for services. Providers should use the Healthy Blue ID number to bill for newborn services.

Providers must notify the SCDHHS of the newborn's birth through completion of the Request for Medicaid ID Number form and send this form to the provider's local or state department of health and human services office. The SCDHHS will return a notice confirming eligibility and provide the Medicaid ID. We require providers to send the newborn's information, including the Medicaid ID, to Healthy Blue five business days prior to billing for services in one of these ways:

- By email to HBProviderService@healthybluesc.com.
- By the Request for Medicaid ID Number form available at www.scdhhs.gov by selecting "Providers."

We cover routine newborn circumcisions during the initial newborn inpatient stay and when performed in a doctor's office for members up to 1 year old. PA is required for any circumcision after 30 days.

Bill circumcision charges with appropriate CPT codes (54150, 54160 and 54161).

Family planning services

Bill family planning services performed by out-of-network Medicaid providers directly to Healthy Blue. Bill family planning services with an FP modifier.

Self-referral services

See the Self-Referral section in Utilization Management for a list of self-referral services.

Specialty referrals

When billing for services a specialty provider rendered after the member's assigned PCP referral, it is necessary to include the individual (type 1) NPI of the member's assigned referring PCP or the provider rendering primary care services in box 17b of the CMS-1500 claim form or for EDI claims (loop 2310A). You can find the NPI from the referring physician or on the NPI registry website at npiregistry.cms.hhs.gov.*

Entering the NPI on the CMS-1500

When submitting claims for services provided to a member not assigned to you, enter the individual NPI (not the billing NPI) of the referring PCP in box 17b on the CMS-1500 claim form. For EDI claims, enter the individual NPI in loop 2310A.

To request a PA, report a medical admission or ask questions about a PA, fax your request to 800-823-5520 or call 866-757-8286 to reach our Utilization Management (UM) department.

Exceptions

There are exceptions to the requirement of providing the referring PCP's NPI when submitting a claim for services provided to a member not assigned to you. These include:

- Emergency services (services performed in place of service 23).
- Ambulance services.
- Family planning services.
- Diagnostic specialties such as lab and X-ray services.
- Anesthesia claims.
- Professional inpatient claims.
- Ambulatory surgical center facility claims.
- DME.
- Home health.
- Professional newborn services for the first 30 days of life.
- Native American health provider, urgent care centers and health departments.

Billing sterilization claims

To satisfy federal and state regulations, document nontherapeutic sterilization with one completed form: the Consent for Sterilization form (HHS-687). We require members to give informed consent on this form. This form is available at www.HealthyBlueSC.com.

The member is required to provide informed consent no less than 30 calendar days (or no less than 72 hours in the case of premature delivery or emergency abdominal surgery) but no more than 180 calendar days before the date of the sterilization. We require a new consent form if 180 days have passed before the surgery is provided. The consent form must be submitted with the claim form.

Tonsillectomies

PA is required for the procedures corresponding to the following procedure-specific and age-specific CPT codes:

- 42820
- 42821
- 42825
- 42826

Vaccine Assurance for All Children (VAFAC)

Providers that are part of the VAFAC Program can get free vaccines from the state for children under age 21. Healthy Blue covers the administration of the immunization if the provider is enrolled in the VAFAC Program.

Procedure codes for the administration of vaccines provided through the VAFAC Program for children under age 21 are as follows:

- 90460 — immunization administration through age 18 via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component (one unit per date of service)
- 90461— each additional vaccine component (two units per date of service)

Note: Healthy Blue requires providers to bill the vaccine codes for reporting purposes.

For more information about the VAFAC Program, call 800-277-4687.

Immunizations and vaccines

Managed care organizations are required to cover all Advisory Committee on Immunization Practices (ACIP) recommended vaccines under the medical or pharmacy benefit.

All FDA approved and ACIP recommended vaccines are covered with no cost share to the member.

When billing for vaccines for members 19 years of age and older, providers should bill for both the vaccine and the immunization administration code. For administration of the vaccine, providers should bill the CPT code 96372. Federally qualified health centers should not bill for immunization administration but may bill for the vaccination in addition to an encounter code.

Coverage for children through 18 years of age continues to be provided through the Vaccine for Children (VFC) Program. The SCDHHS continues to reimburse for the administration of age-appropriate vaccinations provided to children when they get the vaccine through the VFC Program.

For children under age 19 use admin codes **90460 – 90461**. For adults use admin codes **90471 – 90474**. The appropriate admin code should be selected based on the service performed and applicable coding rules.

For questions related to VFC or to enroll in that program, Medicaid providers should contact the South Carolina Department of Health and Environmental Control at:

- Division of Immunization and Prevention
- South Carolina Department of Health and Environmental Control

Mills/Jarrett Complex
PO Box 101106
Columbia, SC 29211-0106

803-898-0460 or **800-27-SHOTS** (outside of the Columbia area)

Healthy Blue providers should direct questions about claims and specific authorization to Provider Service. Any future changes to reimbursement rates for these immunizations are communicated through the standard fee schedule update process.

Vision services

Healthy Blue covers routine vision services (exam and refraction). These services are covered through Vision Service Plan (VSP). The benefit covers a routine eye exam, a pair of eyeglasses (frames and lenses) and related fitting every 12 months for members under 21 years of age. For members 21 years of age and older, the benefit covers a routine eye exam every 12 months and a pair of eyeglasses (frames and lenses) and related fitting every 24 months.

There is a $3.30 copay for members 19 years of age and older who see an optometrist or ophthalmologist (eye doctor) for medical reasons. When medically necessary and approved ahead of time, other services are covered during the 365-day period.

Well-child and sick-child visits billed together

Providers can bill claims for sick-child and well-child visits performed on the same day. Use modifier 25 on the line with the well-child evaluation and management code to bill for a sick visit and a well-child visit performed on the same day. Only use modifier 25 to document a distinct, separately identifiable reason for the office visit and the well-child visit.

Visit type	New patient	Established patient
Well-child visits with modifier 25	99381 – 99385	99391 – 99395
Sick-child visits	99201 – 99205	99211 – 99215

Ancillary Billing Requirements by Service Category

This section provides special billing requirements applicable to each service listed. The member's benefits may not cover some of the services listed. Please be sure to confirm benefit coverage. Also, consult your Provider Agreement for specifics about billing for any of these or other services.

The majority of ancillary claims submitted are for:

- Laboratory and diagnostic imaging.
- DME.

Laboratory billing

To submit laboratory claims, refer to these guidelines:

- Billing requirements per contract: Billing requirements apply to all member claims, except some services administered through the SCDHHS and other state contract programs.
- System edits: Edits are in place for both electronic and paper claims. We cannot readily process claims not submitted in accordance with requirements and we will likely return them.
- Valid coding: We require valid HCPCS or CPT codes for all line items you bill, whether sent on paper or electronically. Refer to the specific service category for special coding requirements.
- Itemization: Itemized services when the "from" and "through" service date is the same.
- Medical records: We might request medical records for certain procedures for determination of medical necessity.
- Modifiers: Modifiers should be used in accordance with the provider's specific billing instructions.
- Unlisted procedures: Physicians may perform services or procedures that are not found in CPT. Therefore, we designated specific code numbers for reporting unlisted procedures. When you use an unlisted procedure code, you need a description of the service to calculate the appropriate reimbursement, and we may request medical records.

LABORATORY SERVICES

The laboratory benefit manager for all laboratory services is Avalon. Avalon does not manage services in an emergency room or hospital inpatient setting. All laboratory claims are filed directly to Healthy Blue.

Lab Prior Authorization

Prior authorization is required for certain laboratory tests such as genetic testing, cytogenic testing and Molecular Pathology. Review the complete list for lab tests that require prior authorization on the website www.HealthyBlueSC.com.

To request authorization:

- Fax to Avalon: 813-751-3760
- Call: 844-227-5769

Medical Policies

Prior to performing or requesting a specific test, review the appropriate medical policy. There are certain requirements for tests that should be reviewed thoroughly. Procedure codes that are listed in the medical policy are not a guarantee of payment and are included only as a general reference tool. The procedures listed may not be all-inclusive. The medical policies can be found on the website www.HealthyBlueSC.com.

Determine coverage of laboratory services

There are certain policy rule criteria that is used to determine coverage for laboratory services.

Policy Rule Definition

- Experimental and Investigational - Procedure is not covered under the member's benefit due to exclusion
- Demographic Limitations - Limitations based on patient age
- Excessive Procedure Units - Total units within and across claims for a single date of service more than necessary
- Excessive Units per Period of Time - Maximum allowable units within a defined period of time has been exceeded

- Insufficient Time Between Procedures - Minimum time required before a second procedure is warranted
- Rendering Provider Limitations - Providers/Procedures not permitted in combination
- Diagnosis Does Not Support Test Requested - Procedure was not appropriate for the clinical situation
- Mutually Exclusive Codes - The procedure is not valid with other procedures on the same date of service

Laboratory Disputes

All laboratory provider disputes should be sent to Healthy Blue except for the Avalon contracted labs. Send the provider disputes to Healthy Blue at the following address:

Attn: Healthy Blue
PO Box 100317
Columbia, SC 29202-3317

Diagnostic imaging billing

To submit diagnostic imaging claims, refer to these guidelines:

- Billing requirements per contract: Billing requirements apply to all member claims, except some services administered through the SCDHHS and other state contract programs.
- System edits: Edits are in place for both electronic and paper claims. We cannot readily process claims not submitted in accordance with requirements and we will likely return.
- Valid coding: We require valid HCPCS or CPT codes for all line items billed, whether sent on paper or electronically. Refer to the specific service category for special coding requirements.
- Contract change during course of treatment: When a contract change impacts a provider's reimbursement during a course of treatment, we require providers to split the dates of service for us to cover services at the new rate.
- Itemization: Itemize services when the "from" and "through" dates of service listed on the claim are the same (for instance, you billed multiple services for a single date).
- Medical records: We might request medical records for certain procedures for determination of medical necessity.
- Modifiers: Use modifiers in accordance with the provider's specific billing instructions.
- Unlisted procedures: There may be services or procedures physicians perform that are not found in CPT. Therefore, we designated specific code numbers for reporting unlisted procedures. When you use an unlisted procedure code, you need a description of the service to calculate the appropriate reimbursement, and we may request medical records.

DURABLE MEDICAL EQUIPMENT (DME)

We cover DME when prescribed to preserve bodily functions or prevent disability.

DME PA review

All custom-made DME requires PA review. Some other DME services may require PA review. Prior to dispensing, please contact our UM department to determine if the DME services require PA review. We deny services that require PA review if you do not get approval from UM. The UM department reviews for medical necessity for all requested services requiring PA review.

The presence of a HCPCS code does not necessarily indicate benefit coverage or payment for a particular service. Some DME codes may be "by report." These require additional information for PA review and for processing at the point of claim.

DME billing

DME providers should bill with the appropriate modifier to identify rentals versus purchases (new or used). We cover claims that lack the appropriate modifier at the rental price.

Follow these general guidelines for DME billing:

- Use HCPCS codes for DME or supplies.
- Use miscellaneous codes, such as E1399, when a HCPCS code does not exist for that particular item of equipment. You cannot use an unlisted code like E1399 to describe an expensive or difficult-to-order item when an adequate code exists for that item. (E1399 is durable medical equipment, miscellaneous, and is by report.)

- Attach the manufacturer's invoice or the manufacturer's pricing list to the claim if using a miscellaneous or unlisted code, such as E1399. We require that the invoice be from the manufacturer, not the office making a purchase. If you submit both the manufacturer's invoice and manufacturer's pricing list, we calculate reimbursement at the lesser of the two.

We do not accept unlisted codes if valid HCPCS codes exist for the DME and supplies you are billing.

We only cover claims for cranial remolding orthotic devices that we authorize and that a pediatric neurosurgeon; pediatric neurologist; pediatric ear, nose and throat (ENT) physician; or a cranial facial surgeon request. We limit coverage to cranial remolding orthotic devices prescribed as orthotic and adjunct to surgical therapy for craniosynostosis.

DME rental

We require medical documentation from the prescribing doctor for DME rentals. Most DME is dispensed on a rental basis only. Rented items remain the property of the DME provider until the purchase price is reached.

DME providers can use normal equipment collection guidelines. Healthy Blue is not responsible for equipment members don't return. We do not accept charges for rentals exceeding the reasonable charge for a purchase, and you may get rental extensions only on approved items.

DME purchase billing

We may cover DME on a rent-to-purchase basis over a period of 10 months, unless specified otherwise at the time of UM review.

Wheelchairs/wheeled mobility aids

Claims examiners follow Medicaid guidelines when calculating payments for by report (that is, no set pricing and determined by actual cost) wheelchair claims. We require "by report" claims on CMS-1500 claim forms to accompany either:

- Manufacturer's purchase invoice.
- Manufacturer's suggested retail price from a catalog dated before Aug. 1, 2003. If the item was not available before Aug. 1, 2003, we require you to submit claims with a manufacturer's purchase invoice, the catalog page that initially published the item and the manufacturer's suggested retail price (MSRP). We require you document the initial date of availability in the "Reserved for local use" field (box 19) of the claim.

Required documentation includes the following:

- Item description
- Manufacturer name
- Model number
- Catalog number

Completion of the "Reserved for local use" field (box 19) on the CMS-1500 claim form with the total MSRP of the wheelchair, including modifications or replacement parts, and the name of the employed Rehabilitation and Assistive Technology of America-certified technician.

We require providers to mark each catalog page or invoice line so it can be matched to the appropriate claim line.

For scooters, in addition to the listed requirements, we require:

- Providers make the invoice amount be what the manufacturer published before Aug. 1, 2003.
- Providers to list the date of availability in the date of availability in the "Reserve for local use" field (box 19) of the CMS-1500 claim form if the item was not available before then.
- Providers to attach the catalog page that initially published the item to the claim.

We require that wheelchair claims from manufacturers billing as providers include:

- The suggested MSRP from a catalog page dated before Aug. 1, 2003. If the item was not available before Aug. 1, 2003, we require that the manufacturer's invoice accompany the claim.
- The initial date of availability in the "Reserve for local use field" (box 19) of the CMS-1500 claim form.

Modifiers

For a listing of DME modifier codes, please access Appendix A of the HCPCS 2007 publication available from the American Medical Association. You can log in to its website, **www.ama-assn.org***, for online access.

OTHER SERVICE TYPES

Ambulance

Ambulance services, including municipalities, should use a CMS-1500 form to bill for ambulance services. Use appropriate two-digit origin and destination codes that describe the "to" and "from" locations. To verify medical necessity, we require an ambulance run report with each claim. A run report must be maintained in the provider's files for each claim and is subject to audit review as requested.

You can find more information about requirements for ambulance services in the South Carolina Ambulance Services Manual.

Dialysis

You can find more information about requirements for dialysis services in the Physicians Services Provider Manual and Hospital Services Manual.

Home health care billing

Members have a 50-visit limit per benefit year for home health services with the following codes: 36415, S9128, S9129, S9131, T1021, T1028, T1030 and T1031. We require PA for all home health care. Contact our UM department for authorization prior to delivery of the service.

Home infusion therapy billing

To submit home infusion therapy claims, refer to these guidelines:

- Submit all claims within the contracted filing limit.
- We require authorization from our UM department for all infusion therapy. Get PA before you render the services.
- We require providers to use the appropriate HCPCS injection codes to bill for all injections listed in the Physicians Services Provider Manual and Hospital Services Manual.
- Use HCPCS code J3490 with the NDC number, drug name and dosage for billing injections only if you don't find an appropriate injection code.
- We require providers to use the appropriate codes to bill for medical supplies and accessories shown in the medical supplies lists found in the SCDHHS Provider Manual.

We cover "by report" HCPCS codes for supplies and accessories are covered at the lesser of:

- The amount billed.
- Wholesale cost plus 25 percent.
- 90 percent of MSRP.

Synagis

To submit Synagis claims, refer to these guidelines:

- Providers should submit CPT-4 diagnosis code 90378 and the appropriate number of units; one unit of 90378 is equivalent to 50 mg. Providers can bill for administration using code 90772.
- Providers should always submit the patient's weight for the date of service they are billing.

Skilled nursing facilities (SNFs)

Healthy Blue covers care in an SNF for the first 90 continuous days or until the member is disenrolled from Healthy Blue and reenrolled into Healthy Connections.

We require PA for all SNF care. Authorization for admission to the SNF setting requires submission to the Health Plan of the completed and signed Form 185 — Level of Care Certification Letter from the state of South Carolina. For concurrent review (recertification), a completed and signed Form 185 — Level of Care Certification Letter with the new effective and expiration dates is required for continued authorization.

Form 185 — Level of Certification Letter can be found at www.scdhhs.gov/internet/pdf/manuals/Nursing/Forms.pdf.

For additional questions, or for PA prior to SNF admission, contact the Utilization Management Department at 866-757-8286

Ambulatory surgical centers

Some outpatient surgery delivered in an ambulatory surgical center needs PA.

Pharmaceuticals

When using an unlisted CPT-4/HCPCS code, provide the NDC number; name of the drug or medication; and dosage in, after or under the procedure code in box 24D on the CMS-1500 form.

BILLING INSTITUTIONAL CLAIMS

This section describes billing guidelines for institutional claims.

CMS-1450 (UB-04) CLAIM FORM

Who should use the CMS-1450 (UB-04) claim form?

Facilities should bill Healthy Blue using the most current version of the CMS-1450 (UB-04) claim form.

Completing a CMS-1450 (UB-04) claim form

Complete all the fields for reimbursement.

Billing for rendering providers

Rendering providers need to supply their nine-digit federal tax ID number when filing claims.

Coding

To be sure we process claims in an orderly and consistent manner, we use standardized code sets. The HCPCS provides codes for billing for a variety of services. These codes are sometimes called national codes. HCPCS consists of two principal subsystems, referred to as Level 1 and Level 2 of the HCPCS.

Level 1 consists of CPT codes the AMA maintains. CPT codes have five numeric digits.

Level 2 consists of other codes that identify products, supplies and services not included in the CPT codes, such as ambulance and DME. These are sometimes called the alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character modifier codes should accompany the Level 1 or Level 2 coding.

Note: Per the SCDHHS, providers may only bill 50 lines on institutional claims.

Inpatient coding — institutional

UB-04 revenue codes: Code claim forms using appropriate UB-04 revenue codes. To order the current billing procedures manual, call 800-621-8335.

ICD-10 procedure codes: Applicable ICD-10 procedure codes should be in boxes 80 – 81 of the UB-04 form when the claim indicates a procedure was performed. To order the current code book, please call **800-621-8335**.

Please refer to the provider's contract for disease-related group information.

Outpatient coding — institutional

HCPCS: Refer to the current edition of HCPCS CMS publishes. To order, call **800-621-8335**.

CPT: Refer to the current edition of the Physicians' CPT manual, published by the AMA. To order, call **800-621-8335**.

All outpatient claims require revenue codes. Refer to Section 4 of the SCDHHS Hospital Services Provider Manual for a list of revenue codes that require procedure codes and a list of revenue codes that do not.

Modifier codes: Use modifier codes when appropriate. Refer to the current edition of the Physicians' Current Procedural Terminology manual the AMA publishes.

Billing for Observation

Observation is billed using revenue codes 762 and 769 and time units reported in one-hour increments. The maximum number of units allowed for an episode of care is 48.

Observation is defined as "the use of a bed and periodic monitoring by hospital nursing or other staff which are reasonable and necessary to evaluate an outpatient's condition to determine the need for inpatient admission."

The criteria for observation services include the following basic provisions:

Revenue codes 762 and 769

- Observation services are covered only upon written order of a physician. This order must document the medical necessity for services, and it's retained as part of the patient's medical record.

- Observation does not require PA.
- Charges for observation services which will result in inpatient admission are deemed to be a part of the admission and not separately billable.

Member ID number

Use the member's Healthy Blue ID card number on all claims you submit, not the number on the Medicaid ID card SCDHHS issues. Always file the member's ID with the three-byte alpha-prefix ZCD when filing claims.

Required fields for filing a Medicaid claim on a CMS-1450 (UB-04) Form

When filing a paper claim for institutional claims, use the CMS-1450 (UB-04) paper claims form. For examples or explanations of the fields, refer to the SCDHHS Hospital Services Provider Manual.

When filing an institutional claim for Healthy Blue services, Healthy Blue requires you to complete these fields for a correctly completed clean claim submission.

CMS-1450 (UB- 04) field title	Description
1	Provider's name, street address, city, state, ZIP, telephone
4	Type of bill
5	Federal nine-digit tax ID number
6	Statement covers from/through
8a – b	Patient's name
9a – e	Patient's address: Enter street address, city, state and ZIP code
10	Patient's birthdate
11	Sex
12	Admission date
13	Admission HR: the time the member is admitted
14	Admission type
15	Admission SRC
16	DHR
17	STAT
18 – 28	Condition codes, if applicable
31 – 34	Occurrence code/date, if applicable: For delivery services, enter the occurrence code "10" in boxes 32 – 36 with the date of the LMP in the box next to the one the provider used for the occurrence code.
42	Revenue code
44	CPT/HCPCS code
45	Service date
46	Service units
47	Total charges
50	Payer identification
54	Prior payments — payer
56	NPI: Enter facility NPI
58	Insured's name
60	Insured's unique ID: Enter the member's plan ID including the alpha-prefix ZCD, followed by the member's 10-digit ID number. Do not enter the number on the Medicaid ID card issued by the state.
63	Treatment authorization code
67	Principal diagnosis code
74	Principal procedure code/date
76	Attending physician name (last, first) and identifiers
81a – c	Taxonomy code and qualifier

HOSPITAL AND INSTITUTIONAL BILLING REQUIREMENTS BY SERVICE CATEGORY

This section provides special billing requirements applicable to each service listed. The member's benefits may not cover some of the services listed, so it is important to confirm benefit coverage. Also, consult your Provider Agreement for specifics about billing for any of these or other services.

Maternity

The billing requirements for maternity care apply to all live deliveries and stillbirths and include payment for all associated services, including but not limited to room and board for mother (including all nursing care), delivery room/surgery suites, equipment, laboratory, radiology, pharmaceuticals, and other services incidental to admission. Bill the baby's claim separately from the mother's claim. The newborn disease-related group (DRG) covers the nursery, nursing care and so forth.

Therapeutic abortions are excluded for payment under this rate as are treatment for ectopic and molar pregnancies and/or similar conditions.

The delivery DRG covers the entire admission, except for admissions approved for extension beyond what is contractually indicated on the continuous inpatient days. In such cases, the inpatient acute care requirements apply for each approved and medically necessary service day for the entire admission, unless otherwise indicated.

Entering the last menstrual period (LMP)

Please follow these guidelines, depending on electronic or paper billing:

- For the CMS-1450 (UB-04) claims form, enter the occurrence code "10" in boxes 31 – 36 with the date of the LMP in the box next to the one the provider used for the occurrence code.
- For institutional electronic billing (837I), enter occurrence code "10" and the date of the LMP in loop 2300, segment HI, qualifier BH.

Inpatient delivery claims that do not have a member's LMP are returned for that information.

Entering an inpatient facility-delivered newborn's birth weight

Please follow these guidelines, depending on electronic or paper billing:

- For the CMS-1450 (institutional) claim form, enter the newborn's birth weight (in grams) in box 39, 40 or 41 using value code 54 on the UB-04 version of the form.
- For electronic billing, enter the newborn's birth weight in loop 2300, segment HI with the qualifier BE and the value code 54 in HI01-2 and the newborn's weight in grams in HI01-5.
- We require claims for live birth weights less than 2,500 grams to submit medical records and accompany the newborn's birth certificate for us to pay.
- If there is a coordination of benefits, attach the primary insurance proof of coverage (remittance advice indicating the primary payment).
- On both paper and electronic claims, include the baby's birth weight on the baby's claim, not the mother's.

Note: We deny inpatient newborn claims that do not have the birth weight indicated.

Mail completed claims to the appropriate address or submit them online through My Insurance Manager.

Inpatient acute care

Billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed (not covered under another category in this section) and include but are not limited to room and board (including all nursing care), ER (if connected with admission), urgent care (if connected with admission), surgery and recovery suites, equipment, supplies, laboratory, radiology, pharmaceuticals, and other services incidental to the admission.

Except for emergency admissions, we require UM approval for all admissions. Routine/normal vaginal or cesarean section deliveries do not require PA in network facilities.

Inpatient sub-acute care

Billing requirements for inpatient subacute care include each approved and medically necessary service day in a duly licensed and accredited facility at the appropriate level of care. We consider each inpatient subacute care admission a separate admission from any preceding or subsequent acute care admission. Bill them separately.

Covered services rendered during an admission include but are not limited to room and board (including all nursing care), equipment use, supplies, laboratory, radiology, pharmaceuticals, and other services incidental to the admission.

Subacute care includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

All inpatient subacute care admissions and levels of care require PA.

A treatment plan should accompany all subacute care admissions, including:

- Functional, reasonable, objective and measurable goals within a predictable time frame for each skilled discipline.
- A discharge plan and options that are individually customized that are identified from the admission date and are carried forward from the admission date.
- Weekly summaries for each discipline and biweekly team conference reports.

Emergency room (ER) visits

The billing requirements for an ER visit apply to all emergency cases treated in the hospital ER for patients who do not remain overnight. They cover all diagnostic and therapeutic services provided, including but not limited to facility use (including all nursing care), equipment, laboratory, radiology, supplies, pharmaceuticals and other services incidental to the ER visit. We base ER reimbursement on the diagnosis you bill.

Special billing instructions and requirements:

- We require ICD-10-CM principal diagnosis codes for all services provided in an ER setting.
- Bill each service date as a separate line item.
- Revenue code is 0450.

Refer all members back to the PCP of record for follow-up care. Unless clinically required, follow-up care should never occur in the ER of a hospital.

Urgent care visits

Billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital/outpatient department/ER and include all diagnostic and therapeutic services provided, including but not limited to facility use (including all nursing care), equipment, laboratory, radiology, supplies, pharmaceuticals and other services incidental to the visit.

Urgent care refers to nonscheduled, nonemergency hospital services required to prevent serious deterioration of a patient's health status as a result of an unforeseen illness or injury. Urgent care visits do not apply to those cases that are admitted and treated for inpatient care following urgent care treatment.

Special billing instructions and requirements:

- We require ICD-10-CM principal diagnosis codes for all services provided in an urgent care setting or designated facility.
- Bill each service date as a separate line item.

Required revenue codes:

- ER: 0450
- ER screening: 0451
- Nonemergency: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519 and 0761
- Observation: 0762 and 0769

Outpatient laboratory services

Billing requirements for outpatient laboratory services (not included elsewhere) refer to services that include but are not limited to clinical laboratory tests. These billing requirements include services rendered in relation to an outpatient visit for laboratory services, including but not limited to facility use, nursing care (including incremental nursing), equipment, professional services (if applicable), specified supplies and all other services incidental to the outpatient visit.

Outpatient radiology diagnostic services

Billing requirements for outpatient radiology services (not included elsewhere) refer to services that include but are not limited to radiology. These billing requirements include services rendered in relation to an outpatient visit for radiology, including but not limited to facility use, nursing care (including incremental nursing), equipment, professional services (if applicable), specified supplies and all other services incidental to the outpatient visit. Outpatient radiation therapy is excluded from this service category. Bill it under the requirements of the other service's category.

Outpatient diagnostic services

Billing requirements for outpatient diagnostic services (not included elsewhere) refer to services that include but are not limited to diagnostic tests. These billing requirements include services rendered in relation to an outpatient visit for diagnostic services, including but not limited to facility use, nursing care (including incremental nursing), equipment, professional services (if applicable), specified supplies and all other services incidental to the outpatient visit.

Outpatient surgical services

Billing requirements for outpatient surgical services apply to each outpatient hospital visit for outpatient surgery services, including but not limited to facility use (includes nursing care), equipment, supplies, pharmaceuticals, blood, laboratory, radiology, imaging services, implantable prostheses and all other services incidental to the outpatient surgery visit.

Even though the hospital classifies a service as an outpatient service, if the member is receiving that service in the hospital longer than 24 hours, the hospital should bill at the inpatient DRG rate.

For surgery services that are not defined in the surgery grouping, we might request medical records for review and determination of surgery grouping.

Special billing instructions and requirements:

- Include CPT4/HCPCS codes for each surgical procedure in box 44 (HCPCS/RATES).
- Service dates should accompany each procedure (both principal and other).

Outpatient therapies

Outpatient therapy services include physical therapy, occupational therapy, speech therapy and respiratory therapy. An outpatient therapy visit means a single service date.

Outpatient therapy visits include but are not limited to facility use (including all nursing care), therapist/professional services, supplies, equipment, pharmaceuticals and other services incidental to the outpatient therapy visit.

Special billing instructions and requirements:

Bill each service date as a separate line item or the applicable HCPCS/CPT4 codes.

Required revenue codes (or the applicable HCPCS/CPT4 codes):

- Physical therapy: 042X
- Occupational therapy: 043X
- Speech therapy: 044X
- Respiratory therapy: 041X

CPT code 97352 (cognitive rehabilitation to improve attention, memory and problem solving) requires PA.

Outpatient infusion therapy visit and pharmaceuticals

The outpatient infusion therapy visit billing requirements apply to each outpatient hospital visit for infusion therapy services, including but not limited to facility use (including all nursing care), equipment, professional services, laboratory, radiology, supplies (for example, syringes, tubing and line insertion kits), intravenous solutions (excluding pharmaceuticals), kinetic dosing and other services incidental to the outpatient infusion therapy visit. An outpatient infusion therapy visit means a single service date.

The outpatient infusion therapy pharmaceuticals billing requirements apply to the drugs (for example, chemotherapy, hydration and antibiotics) used during each outpatient visit for infusion therapy services except for blood and blood products, which are considered other services.

Special billing instructions and requirements:

- Revenue codes 026X, 028X, 0331, 0335 or 0940 are required for each outpatient infusion therapy visit.
- When billing therapeutic aphaeresis claims, use revenue code 0940 and list pharmaceuticals as a separate line item.

We require all applicable HCPCS codes for all pharmaceuticals when:

- Billed with revenue codes 0250 – 0252, 0256 – 0259 or 063X; providers should include the units with pharmaceutical CPT4/HCPCS codes.
- Billed with revenue codes 026X, 028X, 0331, 0335 or 0940. (The SCDHHS does not require procedure codes with these revenue codes.)

List each drug for each visit as a separate line item and include a service date.

NATIONAL DRUG CODES (NDCS)

Healthy Blue requires NDCs, unit of measurement and quantity of unit when submitting claims for drugs dispensed in both professional (medical) and institutional (facility) outpatient settings.

When using the CMS-1450 (UB-04) claim form, you must submit this NDC information for paper claims or the equivalent electronic field.

CMS-1450 (UB-04) field number	Description	Guidelines
43	Revenue codes and description	Enter N4 and the 11-digit NDC number (the number on the package or container from which the medication was administered). We also require the unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to three digits) for submission. Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025

HOSPITAL READMISSIONS POLICY

Healthy Blue does not allow separate reimbursement for claims that have been identified as a readmission to the same hospital for the same, similar or related condition within 30 days of discharge from a previous hospital confinement.

Healthy Blue will use clinical criteria and licensed clinical medical review for readmissions from Day 2 to Day 30 to determine if the second admission is for:

- The same or closely related condition or procedure as the prior discharge.
- An infection or other complication of care.
- A condition or procedure indicative of a failed surgical intervention.
- An acute decompensation of a coexisting chronic disease.
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period.
- An issue caused by a premature discharge from the same facility.
- A reason that is medically unnecessary.

We review all rapid readmission claims prior to the Healthy Blue medical director's denial. Providers who disagree with the outcome of that review can file a dispute.

This policy applies only to unplanned admissions to the same or any other facility for the same or similar diagnosis.

REPORTING PROVIDER PREVENTABLE CONDITIONS WITH PRESENT ON ADMISSION CLAIMS

We require hospitals in the Healthy Blue network to report provider-preventable conditions (PPCs) using present-on-admission (POA) claims. This is a list of those PPCs for which Healthy Blue may not pay claims:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage 3 and 4 pressure ulcers
- Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock)
- Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis and secondary diabetes with hyperosmolarity)
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Coronary artery bypass graft — mediastinitis
- Bariatric surgery (laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery)
- Orthopedic procedures (spine, neck, shoulder and elbow)

- Deep vein thrombosis /pulmonary embolism following total knee replacement or hip replacement (not included for Medicaid for pediatric and obstetric populations)
- Surgery on the wrong patient
- Wrong surgery on a patient
- Wrong site surgery

Table of indicator codes for PPC forms

The table includes indicator codes to be used on the PPC form. Using the codes correctly ensures that you are reimbursed as appropriate.

Indicator	Description	Reimbursable
Y	The condition was present on admission.	Yes
N	The condition was not present on admission.	No
W	The provider determined that it was not possible to document if the condition was present on admission.	Yes
U	The documentation was insufficient to determine if the condition was present on admission.	No

Indicator code usage and examples

Indicator code usage is different for electronic and paper claims.

For electronic claims, the PPC indicator codes follow the diagnosis code in the appropriate 837i 2300 HI segment. They must be within 2300 HI01-09 – HI12-09 in accordance with the number of diagnosis codes billed.

Examples of diagnosis codes with PPC data:

- HI*BK:5770:::::::Y~
- HI*BJ:78906~
- HI*BF:3051:::::::Y*BF:4019:::::::Y*BF:3384:::::::Y*BF:77210:::::::Y*BF:V5869~

For paper claims, the PPC indicator code is the eighth digit of field locator (FL) 67, principal diagnosis and secondary diagnosis fields, FL 67 A – Q. If the diagnosis is exempt from PPC reporting, leave this field blank.

UTILIZATION MANAGEMENT

Our Utilization Management (UM) program collaborates with providers to promote and document the appropriate use of health care resources. The program reflects the most current UM standards from the National Committee for Quality Assurance (NCQA).

The UM department takes a multidisciplinary approach to provide health care services in the setting best suited for the medical and psychosocial needs of the member based on their benefit coverage, established criteria and community standards of care. In coordination with providers, UM assists in providing the right care to the right member at the right time and in the right setting.

ROLE OF UTILIZATION MANAGEMENT

Medically necessary services are those services used in the state Medicaid program, including quantitative and nonquantitative treatment limits as indicated in state statutes and regulations, the state plan, and other state policy and procedures. For Healthy Blue to pay benefits, the member must be eligible, and we must cover the services at the time the provider renders the services. A determination of medical necessity is not a guarantee of payment.

SERVICE REVIEWS

The UM department provides PA, continued stay and post-service reviews using clinical criteria based on evidence-based clinical guidelines and medical policies. These criteria are available to members, physicians and other health care providers upon request by contacting the UM department at 866-757-8286.

Language assistance is available to help members discuss UM issues.

AVAILABILITY OF UM STAFF

After normal business hours, an answering service is available to take UM-related messages. A UM staff member returns calls the next business day. When making or receiving calls, the UM staff member will always give his or her name, job title and the name of the health plan. For after-hours assistance with information not available on the website, call Provider Service at 866-757-8286 to be connected to after-hours support staff.

We ensure availability of UM staff at least eight hours a day on normal business days to answer UM-related calls. Provider Service triages member and provider UM-related calls, and UM staff handles them.

DECISION MAKING

UM decisions are only based on appropriateness of care, service and existence of coverage. We make UM decisions affecting the health care of members in a fair, impartial, consistent and timely manner. We do not reward practitioners and other people conducting utilization review for issuing denials of coverage or care.

There are no financial incentives for UM decision makers to encourage decisions that result in underutilization. Decisions are made and supported at the Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC) for appropriate provisions of medical services and recommendations for UM activities.

DECISION AND SCREENING CRITERIA

We align decision and notification time frames for approval, modification, deferral and denial with the NCQA, contracts and other applicable legislation.

The UM department uses the following criteria when making medical necessity determinations:

- Applicable state and federal guidelines
- Member benefits
- Medical policy and clinical and preventive guidelines
- MCG Care Guidelines (formerly Milliman Care Guidelines)
- AIM Specialty Health® guidelines

Nationally developed procedures for applying criteria, particularly those for lengths of hospital stays, often are designed to be appropriate for the uncomplicated patient and for a complete delivery system. They may not be appropriate for the patient with complications or for a delivery system that does not include sufficient alternatives to inpatient care for the particular patient. Therefore, the UM department considers at least these factors

when applying criteria to a given person:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Individual circumstances

The UM department also considers characteristics of the local delivery system available for the particular patient, such as:

- Availability of SNFs, subacute care facilities or home care available to support the patient after hospital discharge.
- Coverage of benefits for SNFs, subacute care facilities or home care when needed.
- Ability of local hospitals to provide all recommended services within the estimated length of stay.

Decision criteria incorporate nationally recognized standards of care and practice from sources such as the American College of Cardiology, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Orthopedic Surgeons, current professional literature, and cumulative professional expertise and experience. The decision criteria the clinical reviewers use are evidence-based and consensus-driven. We periodically update criteria as standards of practice and technology change. We also involve actively practicing physicians in the development and adoption of the review criteria.

These criteria are available to members, physicians and other health care providers upon request by contacting the UM department at 866-757-8286.

PA AND NOTIFICATION PROCESS

PA is the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medic al history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. "Prospective" means the coverage request occurred prior to the service being provided.

The Forms Resource Center in My Insurance Manager is the preferred method for submitting PA requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for our members.

To request PA, report a medical admission or ask questions about PA, please contact the UM department at 866-757-8286 or fax your physical health PA request to 800-823-5520.

What to have ready when calling UM

We require physicians, hospitals and ancillary providers to provide information and documentation to UM. We also encourage physicians to review their utilization and referral patterns. To speed up the process, please have this information ready when calling:

- Member's name and ID number
- Diagnosis with the ICD-10 code
- Procedure with the CPT code
- Date of injury/date of hospital admission and third-party liability information (if applicable)
- Facility name (if applicable)
- PCP name and TIN
- Specialist or attending physician's name and TIN
- Clinical justification for the request
- Results of lab tests, radiology and pathology
- Medications
- Treatment plan with time frames
- Prognosis
- Psychosocial status
- Exceptional or special needs
- Ability to perform activities of daily living
- Discharge plans

Prior Authorization review time frames

For routine nonurgent requests, including nonurgent ongoing ambulatory requests, the UM department will complete PA review after receipt of information reasonably necessary to make a decision, not to exceed 14 calendar days from receipt of the request.

Healthy Blue sends requests that do not meet medical policy guidelines to a Healthy Blue physician or medical director for review. Healthy Blue notifies providers within 14 calendar days of receipt of the request of the UM decision. Healthy Blue also sends the member and requesting provider a written notification by mail within 14 calendar days of the receipt of the request of any denial or deferral decision.

For urgent requests, including urgent ongoing requests, the UM department completes PA review within 72 hours of receipt of the request. There are certain circumstances under which the above urgent timelines may be extended.

The organization may extend the time frame once for up to 48 hours for PA urgent requests that lack necessary information.

Requests that do not meet the criteria for an expedited/urgent request are treated as a standard PA request and are reviewed as expeditiously as

the condition requires up to 14 calendar days. The following situations do not meet criteria for an expedited/urgent request and are managed as nonurgent requests:

- Any urgent request that does not meet the state definition of urgent
- The date of service is greater than one week from the request date
- Any request for therapy (occupational, speech or physical therapy) greater than two days from the request date

Extensions of urgent and nonurgent requests:

- The member or their authorized representative or provider may request to extend the decision time frame.
- Members should call the provider who ordered the treatment or Provider Service if they wish to request an extension of an authorization. Providers should call the UM Intake department to request an extension.

If Healthy Blue extends the time frame, we give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. We issue and carry out our determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Requests with insufficient clinical information

For PA requests with insufficient clinical information, we contact the provider with a request for the clinical information reasonably necessary to determine a medical necessity. We make at least one attempt to contact the requesting provider to get the additional necessary clinical information.

If we do not receive the information, we send a denial letter to the member and provider within 14 calendar days of the date of the request. For routine nonurgent requests, we may extend the time frame for another 14 calendar days if the member or the member's provider requests an extension or Healthy Blue provides evidence satisfactory to the SCDHHS that a delay in rendering a decision is in the member's best interest.

Generally speaking, the provider is responsible for requesting a PA review for both professional and institutional services. The hospital or ancillary provider, however, should always verify the PA review status on nonurgent services before rendering services.

Emergency medical conditions and services

We do not require PA for treatment of emergency medical conditions. In the event of an emergency, members can access emergency services 24/7.

Members who call their PCP's office reporting a medical emergency, either during or after office hours, are directed to dial 911 or go directly to the nearest hospital ER. The PCP or treating physician should triage all nonemergent conditions with appropriate care instructions given to the member.

The ER's treating physician determines the services necessary to stabilize the member's emergency medical condition, including care related to an emergency medical condition provided after a member is stabilized to maintain the stabilized condition or improve or resolve the member's condition. For more information, see the post-stabilization care services rules in 42 CFR 422.113(b and c).

REFERRALS TO SPECIALISTS

The UM department is available to assist providers in identifying a network specialist and/or arranging for specialist care. Below are some items to keep in mind when referring members:

- UM does not require authorization if you are referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.
- UM does require authorization if you are referring a member to an out-of-network specialist.

Provider responsibilities include documenting referrals in the member's chart and requesting that the specialist provide updates on the diagnosis and treatment plan.

CONTINUED STAY REVIEW

Admission and continued stay inpatient reviews

When continued stay is expected to exceed the number of days authorized during PA review or when the inpatient stay did not have PA review, we require the hospital to contact Healthy Blue for continued stay review. In such cases, Healthy Blue requires clinical review for the member admitted as inpatient in an acute care hospital, intermediate facility or SNF. We perform reviews to assess that the medical care rendered is medically necessary and the facility and level of care are appropriate.

The UM department completes continued stay inpatient reviews within 72 hours of receipt of clinical information or sooner if consistent with the member's medical condition. UM requests clinical information from the hospital on the same day of notification of the member's admission/continued stay. If the information provided meets medical necessity review criteria, we approve the request within 72 hours from the time the information is received. Healthy Blue sends requests that do not meet medical policy guidelines to the physician adviser or medical director for review.

Healthy Blue notifies providers within 72 hours of receipt of the request and sends written or electronic notification of denials or modifications to the member and requesting provider.

Healthy Blue makes decisions about approval or denial of urgent care within the urgent continued stay review 72-hour time frame but may extend the time frame when at least one of the following criteria is met:

- The request to approve additional days for urgent continued stay care is related to care Healthy Blue didn't previously approve, and Healthy Blue documents it made at least one attempt to contact the provider and was unable to get the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, Healthy Blue also has up to 72 hours to make the decision.
- If the provider/facility's request to extend urgent continued stay care was not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request may be treated as an urgent PA decision, and Healthy Blue will make the decision within 72 hours.
- The health plan documents that the member voluntarily agrees to extend the decision time frame. In this case, Healthy Blue has up to 72 hours to make the decision.

If we extend the decision time frame and decide the decision is a denial or modification, we notify the provider and member electronically or in writing within 72 hours of receipt of the request.

The UM nurse performs ongoing follow-up continued stay reviews in collaboration with hospital UM staff and provides assistance with discharge planning as needed to facilitate and coordinate the timely transition of care when medically indicated.

Inpatient admission notification

Hospitals must notify UM of inpatient admissions within 24 hours of admission or by the next business day. For medical admissions, call 866-757-8286 or fax the medical admissions form to 800-823-5520.

We require facilities to provide clinical information within 24 hours of the admission notification to facilitate continued stay review, certify approved inpatient days, expedite discharge planning and authorizations, and ensure proper claims payment.

For behavioral health/substance use admissions, call 866-757-8286.

Policy reminder for readmission within 30 days of discharge

Hospital readmission within 30 days of discharge from an admission for a related diagnosis is not reimbursable as a separate admission. This brings our reimbursement policy for readmissions in line with that of the SCDHHS.

Address for reimbursement

Please note the address to use when submitting reimbursement for overpayment:

Attn: Healthy Blue
PO Box 100317
Columbia, SC 29202-3317

DENIAL OF SERVICE/PEER-TO-PEER DISCUSSION

Only a medical or behavioral health physician who possesses an active professional license or certification can deny a service (procedure, hospitalization or equipment) for lack of medical necessity. When a request has been determined not to be medically necessary, we notify the requesting provider of the decision and how he or she can request a peer-to-peer discussion of the case or a dispute.

The UM department has UM policies and procedures that address the availability of physician reviewers to discuss by phone adverse determinations of any type, including those based on medical necessity. Providers can contact the Complex Inquiry Team who handles peer to peer review before being connected to a Medical Director to discuss any UM decision by phone, fax or email.

Phone: 803-264-8114.

Fax: 803-264-9175

E-Mail: Peer.Medical@bcbssc.com

A peer-to-peer request form is required before being connected to a Medical Director. A Provider can access the P2P request form on www.SouthCarolinaBlues.com or The Forms Resource Center.

Utilization of Management (UM) Courtesy Re-evaluations

UM courtesy reevaluations are permitted for denials that were denied due to the following:

- No clinical information was submitted.
- Insufficient clinical information was submitted.

To request a UM courtesy review:

- Submit the request via phone or fax. (Use the number on the member's ID card.)
  - Specify the request is for a reevaluation upon submission.
  - Submit clinical documentation within five business days of the denial notice

POST-SERVICE/RETROSPECTIVE REVIEW

You must exhaust PA review before moving toward post-service/retrospective review. Post-service review determines the medical necessity and/or level of care for services rendered without getting required PA or concurrent review authorization; therefore, we didn't certify any patient days. For inpatient admissions for which the facilities didn't receive notification, we require facilities to submit a copy of the medical record with the claim.

We make the decision to approve, deny or modify post-service requests within 30 calendar days of receipt of the request. If we decide on a denial or modification, we also notify you electronically or in writing within 30 calendar days of receipt of the requests.

SELF-REFERRAL

Members can self-refer to network providers for family planning services, including:

- Health education and counseling.
- Limited history and physical examinations.
- Laboratory tests.
- Diagnosis and treatment of sexually transmitted diseases if medically indicated.
- Mammograms
- HIV testing and counseling.
- Sterilization.
- Pregnancy testing and counseling.
- Annual examination with a network OB-GYN.

SECOND OPINIONS

There is no cost to members for second opinions that an appropriately qualified health care professional provides. When the request involves care from a specialist, we require a provider of the same specialty provide the second opinion, and we require this specialist to be within our network. A second opinion from an out-of-network provider requires PA. The member can select the provider.

For cases in which there is not a provider within the network who meets the specified qualification, Healthy Blue may authorize a qualified provider's second opinion outside of the network upon the member's or provider's request.

PREFERRED PROVIDER PROGRAM

Healthy Blue, in accordance with SCDHHS contractual requirements, offers its participating providers an opportunity to earn preferred treatment (Gold Card) for PA requests. Throughout the year, Healthy Blue will review often-used codes requiring authorization and the volume of approvals to the providers using those codes. Identification of an approval rate of 80 percent or greater would demonstrate appropriate high-quality services following medically necessary criteria. Healthy Blue will monitor at least annually for any changes that would require amendment.

CASE MANAGEMENT

Our case management program affords members and providers expert assistance in the coordination of complex health care. We encourage providers to make use of this effective program.

Healthy Blue provides the following written information to all contracted providers:

- Criteria for determining which members might benefit from case management
- The provider's responsibility in identifying members who may meet case management criteria
- The process for the provider to follow in notifying Healthy Blue when such members are identified
- A description of Healthy Blue's care coordination and case management programs

Referral process

Providers, nurses and social workers, as well as members or their representatives, can refer to case management:

- By calling the Case Management department at 866-757-8286.
- By faxing a completed Case Management Referral form to 803-870-6501. A case manager will respond to the person who submitted the faxed request within three business days.

PROVIDER RESPONSIBILITY

It is your responsibility to participate in the case management process through information sharing, such as medical records, and facilitation of the case management process by:

- Referring members who could benefit from case management.
- Sharing information as soon as possible (for example, during the initial health assessment the PCP identifies case management needs).
- Collaborating with case management staff on an ongoing basis.
- Recommending referrals to specialists as required.
- Monitoring and updating the care plan to promote goal achievement.
- Providing medical information.
- Coordinating county or state services such as public health, behavioral health, schools and waiver programs.

You can call Case Management for assistance at 866-757-8286.

ROLE OF THE CASE MANAGER

After identifying members who meet case management criteria, case managers:

- Develop a care plan.
- Facilitate communication and coordination between all members of the health care team.
- Educate the member and all providers about case management, community resources, benefits, cost factors and all related topics so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services, improving the quality of care and maintaining cost effectiveness on a case-by-case basis.

The case management team includes credentialed, experienced registered nurses and social workers. The case manager or social worker adds valuable skills that address not only the member's medical issues but also his or her psychological, social and financial well-being.

Accessing specialists: access to care unit

Case managers are available to assist PCPs with accessing specialists when needed. For assistance locating a specialist, call Healthy Blue's Case Management department at 866-757-8286. Standing referrals or an approved number of visits for access to in-network specialists do not require PA. Out-of-network referrals to specialists, however, do require PA.

Neonatal intensive care unit transfer

When you request a neonatal intensive care unit (NICU) transfer, Healthy Blue case managers are responsive and supportive facilitators in coordinating the transfer of infants from one hospital to another hospital or from a hospital to a lower level of care. Healthy Blue case managers do not direct the plan of care, although we may initiate a discussion with hospital discharge planners about discharge planning issues. We also may initiate possible consideration by the health care team of a transfer to a lower level of care or transfer to a nontertiary care center.

The decision on when and to what level of care an infant is to be transferred is solely that of the attending physician. Healthy Blue supports your plan of care consistent with clinical practice guidelines and the member's benefits.

Upon request, we assist with transfer coordination once you initiate the transfer. We cover the costs of the transfer that our case managers facilitate. For more information about NICU transfers, call the UM department at 866-757-8286.

PROVIDER CLINICAL GRIEVANCES & DISPUTES

GRIEVANCES

This provider dispute system will be the sole remedy to dispute the denial of payment of a claim or, in the case of a contracted, in-network provider, to dispute the contractor's policies, procedures, rates, contract disputes or any aspect of the contractor's administrative functions. Providers not otherwise acting in the capacity of an authorized representative of a Medicaid managed care member do not have appeal rights with the department.

You may file a grievance at any time. You can file the grievance orally by calling Provider Service at 866-757-8286. You can also submit a grievance in writing by completing a Provider Grievance Form. You can request this form from Provider Service by calling 866-757-8286 or find it on our website, www.HealthyBlueSC.com.

You can also submit a grievance by sending a letter to:

Healthy Blue - Grievances
P.O. Box 100317
Columbia, SC 29202-3317

You will receive written resolution of the grievance within 30 calendar days of our receipt of the grievance. To the extent additional information is required to render a decision on the dispute, the contractor may extend the time frame by 14 calendar days based on mutual agreement of the contractor and you.

MEDICAL NECESSITY DISPUTES

The grievance and dispute time frame may be extended by up to 14 calendar days if more information is needed to resolve the dispute and you and Healthy Blue come to a mutual agreement regarding the extension of the dispute.

Providers and facilities can call the Complex Inquiry Team to initiate the peer-to-peer (P2P) or ask questions by calling 803-264-8114.

They would then leave the following information on the voicemail:

- Member's name
- Member's DOB
- Case reference number
- Dates of service to be reviewed in the P2P
- Attending physician's name
- Attending physician's contact number
- Three dates and times that the attending physician has available to do the P2P

The medical director will make contact on one of the days that the requesting provider gives in the voicemail.

The P2P voicemail is checked multiple times per day by one of our staff to retrieve the P2P requests.

If a P2P request is received, the staff sets up the case for the P2P and routes it to the medical director queue.

Once the medical director has conducted the P2P with the attending physician, the medical director gives the attending physician his decision.

MEMBER GRIEVANCES & APPEALS

WHO CAN FILE THE GRIEVANCE OR APPEAL?

The member does not have to be the one to file a grievance or appeal. Members can choose anyone they want to represent them, including an attorney, relative or health care provider.

You may file a grievance on a member's behalf. This is a member grievance and follows the procedures appropriate to a member grievance. If a provider files a grievance on behalf of a member, the member must sign a Member Grievance Representative Form notifying Healthy Blue of the member's consent for you and/or an authorized representative to represent them in the grievance process.

You may file an appeal on behalf of a member with the member's written consent. If a member would like you or an authorized representative to submit an appeal on their behalf, the member must sign Member Appeal Representative Form notifying Healthy Blue of the member's consent for the provider or authorized representative to represent them in the appeal process. The Member Appeal Representative Form is available to members when we get a provider's request.

Member Appeal Representative Form is available to members when we receive a provider's request.

DEFINITIONS

A **grievance** is defined as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance also includes a member's right to dispute an extension of time proposed by Healthy Blue to make an authorization decision.

An **appeal** is a request to review an adverse benefit determination.

An adverse benefit determination means we:

- Deny or limit the approval of a requested service. This includes the type or level of service.
- Reduce, delay or end a service that was approved before.
- Deny a payment for service in whole or in part.
- Fail to provide services and resolve grievances and appeals in a timely manner.
- Deny a request to get services outside of the network if the member lives in a rural area with only one managed care organization (MCO).
- Deny a request to dispute a financial liability, including cost sharing, copays, premiums, deductibles and coinsurance.

HOW MEMBERS FILE A GRIEVANCE

A member can file a grievance at any time. Members can express dissatisfaction by filing a grievance with Healthy Blue by calling Member Service at 866-781-5094 (TTY: 866-773-9634) or sending a letter or Member Grievance Form to Healthy Blue.

The Member Grievance Form is available online at www.HealthyBlueSC.com. Healthy Blue can also mail the form to members upon request. If a member is unable to submit a form, Healthy Blue can assist the member by documenting a verbal request. Interpreter services are available to assist members with the grievances and appeals process. Written grievances should be sent to:

Attn: Healthy Blue - Grievances
P.O. Box 100317
Columbia, SC 29202-3317

RECEIPT AND ACKNOWLEDGEMENT OF GRIEVANCE

If a member calls into Member Services and files a grievance and the associate resolves the verbal grievance at the point of call or no later than the end of the next business day, the associate will acknowledge the grievance with verbal resolution.

Grievances received by phone, mail, email or fax that cannot be acknowledged and resolved by Provider Service are handled by the Grievances and Appeals department for investigation and resolution.

Within seven calendar days of getting your grievance by phone or in writing, we will send you a letter letting you know we got it. Within 90 calendar days, we will send you a letter that tells you what we've done to resolve your grievance.

WHEN TO EXPECT A RESOLUTION FOR A GRIEVANCE

Within 90 calendar days, we Healthy Blue will send you a letter that tells the member what we've done to resolve the member's grievance.

Healthy Blue may take an extra 14 calendar days if we need more information and time to decide and if the extra time is in the member's best interest. If this happens, we will call you as soon as we can to let you know. We'll also send you a letter within two calendar days.

According to state laws, Healthy Blue may not be able to disclose to members the final disposition of certain grievances. In cases in which Healthy Blue has investigated a provider or in cases related to quality of care, Healthy Blue notifies the member that we received and investigated the grievance, and we inform the member that we cannot disclose the final disposition due to peer review confidentiality laws.

HOW MEMBERS FILE AN APPEAL

A member or representative may file an appeal within 60 calendar days from the date on the Adverse Benefit Determination Notice. Members may appeal an adverse action, such as denial of an authorization, by filing an appeal with Healthy Blue by calling Member Service at 866-781-5094 (TTY: 866-773-9634) or sending a letter to Healthy Blue.

The Member Appeal Request Form is available online at www.HealthyBlueSC.com. Healthy Blue can also mail the form to the member upon request. Written appeals should be sent to:

Attn: Healthy Blue -Appeals
PO Box 100215
Columbia, SC 29202-3215

Member appeals can be faxed to 803-870-6505.

RECEIPT AND ACKNOWLEDGEMENT OF APPEAL

Healthy Blue sends a written acknowledgement of the appeals to the member within 10 calendar days from the date of receipt. The letter acknowledges receipt of the appeal and explains the member's right to send more information in writing or in person.

EXPEDITED APPEAL

Members have the right to request an expedited appeal for urgent medical reasons. Healthy Blue reviews requests for expedited appeals within one working day of receipt to determine if the request involves an imminent and/or serious threat to the health of the member.

If the request meets the criteria for an expedited appeal, Healthy Blue immediately acknowledges this finding by phone if possible. We resolve the expedited appeal within 72 hours of the date we receive the expedited appeal request. We notify the member by phone of the resolution if possible. We send a written resolution letter within 72 hours from the date Healthy Blue receives the expedited appeal.

If Healthy Blue determines an expedited appeal is not medically warranted, we handle and resolve the request as a standard appeal within 30 calendar days of receipt of the appeal request. Healthy Blue makes reasonable attempts to notify the member of this decision by phone or fax. In addition, we send the member a written notice within two calendar days of the decision to deny the request for expedited appeal.

WHEN HEALTHY BLUE NEEDS MORE INFORMATION

Healthy Blue may request medical records or additional explanation of the issues on appeal from the provider. The provider must respond within 7 calendar days of the date of the request for additional information. For expedited appeals, we require the provider to respond within 24 hours of the date of the request for information.

WHEN TO EXPECT A RESOLUTION FOR A CLINICAL APPEAL

Healthy Blue resolves member appeals and notifies members in writing within 30 calendar days of receipt of the appeal.

We may take an extra 14 calendar days if:

- The member or his or her representative asks for an extension to resolve the grievance.
- Healthy Blue needs more information and time to make a decision, and the extension is in the member's best interest.
- Healthy Blue informs the member of the right to file a grievance if the member disagrees with the extension decision within two calendar days.

Healthy Blue sends a written resolution letter to the member within 30 calendar days of receipt of the appeal.

CONTINUATION OF BENEFITS FOR SOUTH CAROLINA MEDICAID MEMBERS DURING CLINICAL APPEAL

A member can request to continue affected benefits while their appeal is pending, in accordance with federal regulations at 42 CFR 438.420, when all of the following criteria are met:

- The member or representative requests benefits continue within 10 calendar days from the date on the adverse determination notice.
- The appeal involves the termination, suspension, or reduction of previously services.
- An authorized provider ordered the services.
- The original period the original authorization covered has not expired.
- The member requests extension of benefits.

If, at the member's request, we continue or reinstate the member's benefits while the appeal is pending, the benefits are continued until one of the following occurs:

- The member withdraws the appeal.
- Ten calendar days pass after the date on the notice, providing resolution of the appeal against the member, unless the member within the 10-day time frame has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached.
- A state fair hearing officer issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service are met.

If the final resolution of the appeal is adverse to the member, where the resolution outcome is upheld, we may pursue recovery of the cost of services furnished to the member while the appeal was pending, to the extent that the services were furnished solely because of the requirements listed above and in accordance with the policy described in 42 CFR §§ 431.230(b) and 438.420.

If the services were not furnished while the appeal was pending and we reverse a decision to deny, limit or delay services, we must authorize or provide the disputed services promptly and as quickly as the member's health condition requires. If we reverse a decision to deny authorization of services and the member received the disputed services while the appeal was pending, we must pay for the disputed services in accordance with state policy and regulations.

STATE FAIR HEARING

Upon exhaustion of our appeal process, if the member is dissatisfied with the appeal decision, the member has the right to request a state fair hearing. The member must request the hearing in writing within 120 calendar days of the date of the appeal resolution letter that states our decision to deny the member's appeal. The 120-calendar-day period is counted from the date the member received a Notice of Appeal Determination Letter.

A state fair hearing is a state-level administrative procedure the Division of Appeals and Hearings at the SCDHHS conducts. At the hearing, the member and/or the member's authorized representative can present evidence to show why the final determination of our appeal process is not fair and should be reversed.

According to federal regulation, a provider is not entitled to a state fair hearing as part of the appeal process. Only the member has that right. The member does have the right to have another person, such as his or her medical provider, file the request for a state fair hearing on his or her behalf and represent him or her at the hearing. It should be noted, however, that a provider cannot require the member to appoint the provider as the member's state fair hearing representative as a condition of continuing to receive services.

If, at the member's request, we continue or reinstate the member's benefits while the appeal is pending, the benefits are continued until one of the following occurs:

- The member withdraws the appeal.
- Ten calendar days pass after the date on the notice providing resolution of the appeal against the member, unless the member within the 10-day time frame requests a state fair hearing with continuation of benefits until a state fair hearing decision is reached.
- A state fair hearing officer issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the member, where the resolution outcome is upheld, we may pursue recovery of the cost of services furnished to the member while the appeal was pending to the extent that the services were furnished solely because of the requirements listed above and in accordance with the policy described in 42 CFR §§ 431.230(b) and 438.420. If the services were not furnished while the appeal was pending and we reverse a decision to deny, limit or delay services, we must authorize or provide the disputed services promptly and as quickly as the member's health condition requires. If we reverse a decision to deny authorization of services and the member received the disputed services while the appeal was pending, we must pay for the disputed services in accordance with state policy and regulations.

Providers do not have a right to the state fair hearing. A provider can only participate in the state fair hearing process if the member has given him or her consent in writing to do so. When a provider files for a state fair hearing on behalf of a member, a copy of the member's written consent must be attached to the state fair hearing request.

A provider who wishes to submit a request for a state fair hearing on behalf of a member must have the member complete and sign a Member Appeal

Representative Form notifying Healthy Blue of his or her consent for the provider to represent him or her in the appeal process. Providers can request the Member Appeal Representative Form by calling Provider Service at 866-757-8286.

Providers can send written requests for a state fair hearing along with the accompanying Provider Appeal Request Form to:

South Carolina Department of Health and Human Services

Division of Appeals and Hearings
PO Box 8206
Columbia, SC 29202

The Member Appeal Representative Form must be included with the mailed request. To learn more about state fair hearings, visit **msp.scdhhs.gov/appeals*** or call 800-763-9087.

CONFIDENTIALITY AND DISCRIMINATION

We handle all grievances and appeals in a confidential manner. Healthy Blue does not discriminate against a member for filing a grievance or for requesting a state fair hearing. Healthy Blue also notifies members of the opportunity to receive information about our grievance and appeal process and the ability to request a translated version in a language other than English.

Grievances and complaints of discrimination

Healthy Blue does not discriminate against any member. Members who contact Healthy Blue with an allegation of discrimination are immediately informed of the right to file a grievance. This also happens when one of our representatives working with a member identifies a potential act of discrimination. The member is advised to submit an oral or written account of the incident and is assisted in doing so if he or she requests assistance.

MEMBER RIGHTS & RESPONSIBILITIES

Please review these guidelines as part of the provider's continuing assessment of office policies and procedures.

MEMBER RIGHTS

Healthy Blue members have the right to:

- Observe and protect their member rights and responsibilities.
- Get the help they need to understand their member handbook.
- Always be treated with respect and due regard for their dignity and privacy.
- Take part in decisions about their health care. (This includes the right to refuse treatment.)
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or action to get back at them as stated in the federal regulations on the use of restraints and seclusion.
- Have access to their medical records and ask that they be changed or corrected as federal and state laws allow.
- Receive health care services they can access statewide.
- Get services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness or medical condition.
- Receive health care services that are similar to those given under Healthy Connections in:
  - Length of time given.
  - Scope.
- Get health care services that are enough in amount, length of time given and scope to do what they should be able to do for their health issue.
- Make an informed health plan choice before joining a plan by getting information about the basic features of managed care, including:
  - Which groups of people may or may not enroll in the program.
  - The health plan's duties for coordinating care in a timely manner.
- Know that Healthy Blue, their doctors and other health care providers cannot treat them differently because of their:
  - Age.
  - Sex.
  - Race.
  - National origin.
  - Gender.
  - Gender identity.
  - Sexual orientation.
  - Language needs.
  - Degree of illness or health issue.
- Receive a candid discussion of appropriate or medically necessary treatment options for their conditions in spite of the cost or their benefit coverage.
- Get care that is medically necessary.
- Get help from the SCDHHS and Healthy Blue in knowing what is required and covered.
- Have no-cost interpreter services if they speak a language other than English or if they have hearing, vision or speech loss.
- Get health plan documents in formats such as Braille, large-size print or audio at no cost to them.
- Get all information and notices in a format that is easy to understand.
- Get information about our organization, its services, its practitioners and providers, and member rights and responsibilities.
- Get information from their health plan about services. This includes but is not limited to:
  - Benefits covered.
  - How to get benefits and approvals from Healthy Blue or their doctor.
  - Cost sharing rules.
  - Service area. (The Healthy Blue service area is every county, statewide in South Carolina.)

  - Names, locations and phone numbers of current network providers (PCPs, specialists and hospital staff) who speak a language other than English.
  - Any limits on their freedom of choice among network providers.
  - Providers who are not taking new patients.
  - Extra benefits not offered by their health plan. Plus, how they may get them and get a ride to and from these services.
- Get a complete outline of their disenrollment rights at least once per year.
- Know that we may make changes to their health plan benefits as long as we tell them about those changes in writing 30 days before they take effect.
- Receive information on the grievance, appeal and fair hearing procedures.
- Get details on emergency and after-hours coverage, including but not limited to:
  - What is an emergency medical condition, emergency services and post-stabilization services?
  - The fact that emergency services do not need an approval from Healthy Blue.
  - The process and procedures for getting emergency services.
  - The fact that they have the right to use any hospital or other setting for emergency care.
  - Post-stabilization care services rules as noted in 42 CFR 422.113(c).
- Have their privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that they are applicable.
- Exercise these rights without adversely affecting the way the MCO, its providers or the SCDHHS treat members.
- Be notified of how to access those services.
- Be told about other treatment choices or plans for care in a way that fits their health issue.
- Know that we only cover health care services that are part of their plan.
- Refuse care from their PCP or other health care providers.
- Find out how we decide if new technology or treatment should be part of a benefit.
- Get 24/7 access to medical advice from their PCP, either in person or by phone.
- Get news about and make an advance directive. This includes a description of state laws that apply to living wills (Chapter 66, Section 44). This also includes changes in the state law as soon as they can be given to them but no later than 90 days after the change goes into effect.
- Change or revoke their advance directive at any time.
- Choose a provider who is part of their network. If they get services from a provider who is not in network or not approved by us, those services will not be covered.
- Get family planning services from a provider not in their network.
- Have problems taken care of fast. This includes things they think are wrong, as well as issues about getting an approval from us, their coverage or payment of services.
- Know the date they join Healthy Blue is used as the date when their benefits begin. We won't cover services they got before this date.
- Question a decision we make about coverage for care they got from their doctor. They will not be treated differently if they make a complaint.
- Make recommendations regarding our rights and responsibilities policy.
- Tell us what they would like to change about our health plan.
- Have news about their health insurance and medical records kept private by us, their doctors and all of their other health care providers.
- Get written documents about this plan that includes information about how the plan is set up and how it operates.
- Get our rules on referrals for specialty care and other benefits not given by their PCP.
- Have their privacy guarded as noted in 45 CFR parts 160 and 164, subparts A and E (as this rule applies).
- Use their rights without being treated differently by us, the providers who contract with us or staff from the SCDHHS.
- Know they will not be held liable if their health plan becomes insolvent.

MEMBER RESPONSIBILITIES

Healthy Blue members have the responsibility to:

- Tell us and their social worker if:
  - They move.
  - They change their phone number.
  - The number of people in their household changes.
  - They have other insurance.
  - They become pregnant.
  - Their ID card is lost or stolen.
- Understand their health problems and help their doctor set mutually agreed upon treatment goals.
- Show their ID cards each time they get medical care.
- Know the plan's procedures.
- Call us if they have questions or want to learn more.
- Make it to their PCP visits and follow-up visits on time. If they cannot make it, change the visit as far in advance as they can.
- Use the ER only for emergency services, not for routine services.
- Pay for services that are not covered by us.
- Treat their PCP and other health care providers with respect.
- Tell us, their doctors and their other health care providers what they need to know to treat them.
- Follow the treatment plans they, their doctors and their other health care providers agree on. If they could not follow them, tell us why.

PROVIDER ROLES & RESPONSIBILITIES

PCP SCOPE OF RESPONSIBILITIES

Healthy Blue members select a contracted PCP as their main provider of health care services within the established period of the effective date of enrollment.

If, after the established period of the effective date of enrollment, the member has not selected a PCP, Healthy Blue assigns a PCP to the member.

PCPs can be general practitioners, family practitioners, internists, OB-GYNs or pediatricians who are chosen or designated for each member and are responsible for coordinating the health care of the member, including necessary referrals to other providers. The PCP's scope of practice includes the development and oversight of the member's treatment and care plan, including availability to health care 24/7. The PCP serves as the primary provider of a member's health care services.

The following people may be chosen or designated, in lieu of a physician, to be responsible for coordinating the health care of the member, including necessary referrals to other providers:

- An advanced nurse practitioner
- A certified nurse-midwife, only if chosen or designated in lieu of a member's PCP during the member's pregnancy and for a period of the month in which the 60-day period following termination the pregnancy ends

Enrolled network providers can use the SCDHHS' model letters to inform members about their participation status in the Medicaid program and Healthy Blue.

Changing a member's PCP

There are several ways to update member's PCP. If a member is interested in updating his or her PCP, he or she can do so in the member portal or by contacting Provider Service at 866-757-8286.

Referrals

PCPs coordinate and make referrals to appropriate specialists, ancillary providers or community services. They monitor and track all services and provide health education information, materials and referrals.

Note: Members have the right to self-refer to an OB-GYN without referrals from their PCPs.

Transitioning members between facilities or to home

PCPs initiate or help with the discharge or transfer of:

- Members at an inpatient facility to a facility of the appropriate level of care (SNF or intermediate rehabilitation facility) medically indicated or home.
- Members who are hospitalized in an out-of-network facility to an in-network facility or to home with home health care assistance (within benefit limits) when medically indicated. The coordination of member transfers from noncontracted out-of-network facilities to contracted in-network facilities is a priority that may require the immediate attention of the PCP. Contact a utilization nurse to assist in this process.

SPECIALIST SCOPE OF RESPONSIBILITIES

Specialist physicians, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PCPs. Access to contracted network specialists is done through the member's PCP. In limited cases, such as family planning and evaluation or in the diagnosis, treatment and follow-up of sexually transmitted diseases (STDs), the member can self-refer.

PCPs refer members to Healthy Blue-contracted network specialist physicians for conditions beyond the PCP's scope of practice that are medically necessary. Specialists diagnose and treat conditions specific to their areas of expertise. Specialist care is limited to Healthy Blue benefits.

We require specialist physicians acting as PCPs to follow the processes listed in the PCP Scope of Responsibilities section. Members with disabling conditions or chronic illnesses or those who are under age 21 with special health care needs can request that their PCPs be specialists. We require specialist physicians acting as PCPs to follow all responsibilities of a PCP.

Subsequent specialist scope of responsibilities:

- Notify the member's PCP when scheduling a hospital admission or any other procedure requiring the PCP's approval.
- Communicate member information for members requiring specialty health services.

Note:

In network: All subsequent visits to the specialist do not require PA as long as the specialist deems the visits medically necessary and the member retains eligibility with Healthy Blue.

Out of network: All subsequent visits to the specialist require PA as long as the specialist deems the visits medically necessary and the member retains eligibility with Healthy Blue.

HOSPITAL SCOPE OF RESPONSIBILITIES

PCPs refer members to Healthy Blue-contracted network hospitals for conditions beyond the PCP's scope of practice that are medically necessary. We limit payment for hospital care to Healthy Blue benefits.

Hospital professionals diagnose and treat conditions specific to the area of expertise.

Notification of admission and services

We require the hospital to notify Healthy Blue or the review organization of an admission or service at the time the member is admitted or service is rendered. If the member is admitted or a service is rendered on a day other than a business day, we require the hospital to notify Healthy Blue of the admission or service the morning of the next business day following the admission or service.

Notification of decision

If the hospital has not received notice of PA review determination at the time of a scheduled admission or service, as the UM Guidelines and the Hospital Agreement require, the hospital should request the status of the determination.

Any admission or service that requires PA review, as discussed in the UM Guidelines and the Hospital Agreement, and has not received the appropriate review may be subject to post-service review denial. Generally, we require the physician to perform all PA review functions. The hospital may ensure, however, before rendering services that such has been performed or risk post-service denial. Refer to the Utilization Management section for PA review time frames. Providers must exhaust PA review before moving toward post-service/retrospective review.

ANCILLARY SCOPE OF RESPONSIBILITIES

Healthy Blue has a network of various participating health care professionals and facilities. Health care professionals provide medically necessary services when a licensed physician or licensed health care professional orders the services and are in accordance with the applicable benefit agreement and Ancillary Agreement. All services the health care professional provides, and for which the health care professional is responsible, are listed in the Ancillary Agreement. We require health care professionals to agree that all medical services they provide or arrange are included in the rates, as described in the Ancillary Agreement.

PCPs and specialists refer members to Healthy Blue-contracted network ancillary professionals for conditions beyond the PCP's scope of practice that are medically necessary. Ancillary professionals diagnose and treat conditions specific to their areas of expertise. We limit ancillary care to Healthy Blue benefits.

RESPONSIBILITIES APPLICABLE TO ALL PROVIDERS

Eligibility verification

We require all providers to verify member eligibility immediately before providing services, supplies or equipment. Eligibility may change monthly, so a member eligible on the 31st of one month may not be eligible on the first of the following month. Healthy Blue is not responsible for charges ineligible people incur. Verify eligibility by using the Healthy Blue website at www.HealthyBlueSC.com or by calling Provider Service at 866-757-8286. Refer to the Member Eligibility section for more information.

Practitioners are notified of the right to review information submitted to support credentialing applications. This right includes access to information from any outside sources, with the exception of references, recommendations or other peer review protected information. In the event that credentialing information cannot be verified or if there is a discrepancy in the credentialing information, credentialing staff will contact the practitioner. This communication will specifically notify the practitioner of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. On request, the practitioner will be provided with the status of their credentialing or recredentialing application.

Prior authorization reviews

You should get PA reviews for:

- Elective surgery in an ambulatory surgical center or outpatient hospital setting.
- Nonemergency hospital admissions, including surgery.

- Out-of-network specialist referrals.
- Custom-made medical equipment.

Additional treatments or procedures listed under PA review as outlined in the Utilization Management section.

Providers should submit PA review requests directly to the UM department according to the utilization review process.

An emergency medical service to triage and stabilize a member does not require PA review.

Collaboration

The provider shares the responsibility of giving considerate and respectful care and working collaboratively with Healthy Blue affiliates, members and their families, specialist physicians, hospitals, ancillary providers, and others for the goal of providing timely, medically necessary and quality health care services. We require providers to permit members to participate actively in decisions about medical care. That includes, except as limited by law, their decision to refuse treatment. The PCP also facilitates interpreter services (see the Interpreter Services section) and provides information about the EPSDT Program.

Communication for continuity of care

The PCP maintains frequent communication with the specialist physician, hospital and/or ancillary provider to ensure continuity of care. Healthy Blue encourages physicians, hospitals and providers of all practices, including behavioral health, to maintain open communication with each other and their patients about appropriate treatment alternatives regardless of their benefit coverage limitations.

Healthy Blue does not penalize physicians, nonphysician practitioners or other health care providers for discussing medically necessary or appropriate patient care.

Healthy Blue established comprehensive and consistent mechanisms to ensure continued access to care for members when physicians terminate from Healthy Blue. Under specified circumstances, members can finish a course of treatment with the terminating physician. For more information, refer to the Continued Access to Care/Continuity of Care section in this manual.

Confidentiality

You must protect and keep confidential all protected health information about Healthy Blue members in compliance with all applicable state and federal laws and regulations. You must safeguard all records, paper and electronic, that document services provided to Healthy Blue members.

Medical records documentation and access to medical records and information

You are responsible for ensuring member medical records are organized and complete. They must include documentation from specialists, hospitals, ancillary providers, carved-out services and community services when applicable. The PCP is required to record the use of any and all interpreter services. We require that documentation be signed, dated, legible and completed in a timely manner. We require medical records to be stored in a secured location.

We require providers to give Healthy Blue prompt access, upon demand, to medical records or information for quality management or other purposes, including utilization review, audits, reviews of complaints or appeals, HEDIS®, and other studies. We require all physicians and providers to provide all medical records and information as requested within the time frame we establish.

We require providers to give Healthy Blue or its external quality review organization access to office sites for facility or medical records reviews upon request. Mandated time limitations for the completion of reviews and studies require the cooperation of the provider to provide medical records in a timely manner. We require providers to have procedures in place to provide timely access to medical records in their absence.

For public health communicable disease reporting, we require providers to provide all medical records or information as requested and within the time frame state and federal laws establish.

Medical record review criteria

Healthy Blue recognizes that the process and the outcome of health care management are found in the member's medical records. A current, well-organized and detailed medical record lets you establish a logical treatment plan based on sound reasoning and provide that care in the safest and most appropriate manner.

The Clinical Quality department conducts medical record reviews to assess PCPs' compliance with Healthy Blue's Medical Record Documentation Standards. Medical records should be organized and should reflect continuity and coordination of care. They should all services provided directly and/or ordered.

The Healthy Blue CQIC approves medical record review standards and goals. We encourage providers to familiarize themselves with these standards, as reflected in our policy and audit tool. You can find these materials on our website at www.HealthyBlueSC.com.

The Clinical Quality department staff conducts a medical record compliance audit (MRCA) of providers on an annual basis until providers achieve a score of 90 percent. The annual MRCA includes a random sample of 30 network providers without consideration of member panel size. Up to five member records for each of the selected providers will be reviewed using a weighted, standardized tool. The provider selection methodology uses the central limit theorem where the sample of 30 represents the larger distribution of network providers, which approximates a normal distribution.

The overall performance standard is a cumulative score of 90 percent. Provider groups scoring below the 90 percent cumulative score are mailed a score letter explaining their deficiencies. A corrective action plan is developed, and a follow-up review is conducted within six months of the score letter date at the applicable office site.

Sites that do not meet the minimum performance standard at the six-month re-audit receive written notification of deficiencies in an updated action plan. A second re-audit within the next six (6) months is scheduled.

If the minimum standards are not met at the second re-audit, the provider group may be referred to the Credentialing Committee based upon the recommendation from the medical director. The Credentialing Committee makes recommendations regarding disciplinary action, i.e., sending a referral to the Physician Disciplinary Committee. The CQIC receives the Credentialing Committee's aggregate report noting the activities performed.

The medical record compliance audit scores are reported annually to the CQIC.

Mandatory reporting of abuse

Providers ensure that office personnel have specific knowledge of local reporting requirements, agencies and procedures to make phone and written reports of known or suspected cases of abuse or other conditions as state law requires. All health care professionals are required to immediately report actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by phone. Providers are required to submit a follow-up written report to the local law enforcement agency within the time frames law requires.

Notifying Healthy Blue of changes

We require you to notify Healthy Blue of any:

- Change in professional business ownership.
- Change in federal nine-digit TIN.
- Change in business address or the location where they provide services.

Legal or governmental action initiated against a health care professional, including but not limited to an action for professional negligence, for violation of the law, or against any license or accreditation that, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement.

Other problems or situations that impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement care review and grievance resolution procedures.

These forms are available for you to use when notifying us of administrative changes in your practice:

- Application To File Claim or Change EIN
- Application for Satellite Location
- Authorization for Clinic/Group To Bill for Services
- Change of Address

You can find these forms inside My Provider Enrollment Portal.

In the event Healthy Blue determines the quality of care or services provided by a health care professional is not satisfactory as may be evidenced by or noted in member satisfaction surveys, member complaints or grievances, UM data, complaints or lawsuits alleging professional negligence, or any other quality-of-care indicators, Healthy Blue may terminate the Provider Agreement.

Health care professionals agree to be bound by and comply with Healthy Blue policies, procedures and rules.

Oversight of nonphysician practitioners

All providers using nonphysician providers are required to provide supervision and oversight of such nonphysician providers consistent with state and federal laws. The supervising physician and the nonphysician practitioner are required to have written guidelines for adequate supervision, and all supervising providers are required to follow state licensing and certification requirements.

Nonphysician practitioners are advanced registered nurse practitioners, including certified nurse-midwives, and physician assistants. These nonphysician practitioners are licensed by the state and work under the supervision of a licensed physician as mandated by state and federal regulations.

Office hours

To maintain continuity of care, we require all PCPs to be available to provide services for a minimum of 24 hours each week. We require the PCPs to be available 24 hours a day by phone or have an on-call physician. We require office hours to be conspicuously posted. For specific hours of operation and after-hours requirements, refer to the Access Standards and Access to Care section.

You must inform members of your availability at each site.

Licenses and certifications

You must maintain all licenses, certifications, permits, accreditations or other prerequisites Healthy Blue and federal, state and local laws require to provide medical services. Copies of licenses, certifications, permits, evidence of accreditations or other prerequisites are in the respective Provider Agreement.

Prohibited activities

We prohibit all providers from:

- Billing eligible members for covered services.
- Segregating members in any way from other persons receiving similar services, supplies or equipment.
- Discriminating against Healthy Blue members.

Open clinical dialog/Affirmative Statement

Do not construe anything within the Provider Agreement or this manual as encouraging providers to restrict medically necessary covered services or to limit clinical dialog between providers and their patients. You can communicate freely with members about the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Notification of panel closure

PCPs who wish to close their panel to new members must notify Healthy Blue 30 days prior to the closure. Submit this notification in writing in one of two ways:

- Via email to your network representative
- Via letter mailed to:

Attn: Healthy Blue
PO Box 100317
Columbia SC 29202-3317

Healthy Blue acknowledges receipt and advises practices of the date of panel closure based upon the receipt date of the notification.

Note: Healthy Blue does not accept phone notification of panel closure. The notification must be in writing.

Provider terminations

The participating provider or participating physician group is responsible for notifying Healthy Blue of the intension to terminate from Healthy Blue provider network. When a PCP terminates, Healthy Blue notifies all members assigned to the terminating provider or physician group that the provider is terminating and will no longer be available as a physician participating in the provider network.

Providers should refer to their Provider Agreement for termination responsibilities and time frames.

Healthy Blue will notify providers of significant program changes, including network changes, 30 days prior to the date the change takes effect.

Provider rights

Physicians and other health care providers have rights and responsibilities as health care providers.

These rights and responsibilities are communicated to providers through this manual.

Please review these guidelines as part of your continuing assessment of office policies and procedures. Healthy Blue providers have the following rights:

- To receive information on grievances and disputes.
- To have access to policies and procedures covering authorization of services.
- To be notified of any decision to deny a service authorization request or to authorize a service in an amount, duration or scope less than requested.
- To challenge, on behalf of the Medicaid members, the denial of coverage of or payment for medical assistance.
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable law, solely on the basis of that license or certification.

Additionally:

- A health care professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his or her patient for:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs to decide among all relevant treatment options.
  - The risks, benefits and consequences of treatment or nontreatment.
  - The member's right to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.
- Healthy Blue provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment.

ACCESS STANDARDS & ACCESS TO CARE

Appointment standards

We base standards for appointment scheduling on guidelines published by the American College of Obstetricians and Gynecologists and the National Committee for Quality Assurance as well as contractual requirements put forth by the SCDHHS.

We require PCPs and specialists to meet standards for appointment scheduling to ensure Healthy Blue members have timely access to medical care and services. Healthy Blue monitors provider compliance with appointment access on an annual basis.

Medical appointment standards

We require PCPs and specialists to make appointments for members from the time of request.

General appointment scheduling:

- Emergent or emergency visits: immediately upon presentation at a service delivery site 24/7
- Urgent, nonemergency examinations: within 48 hours of request
- Routine care visits: within four weeks of request
- Health maintenance and preventive care: within eight weeks

Behavioral health appointment scheduling:

- Emergent (non-life-threatening) visits within six hours
- Urgent, nonemergency examinations: within 48 hours of request
- Routine care visits: initial visit for routine care within 10 business days
- Follow-up visit for routine care within 30 business days of initial visit

Wait time should not exceed 45 minutes of arrival time for scheduled appointments of a routine nature. Walk-in patients with nonurgent needs should be seen, if possible, or scheduled for an appointment consistent with written scheduling procedures. Walk-in patients with urgent needs should be seen within 48 hours.

MISSED APPOINTMENT TRACKING

When members miss appointments, we require you to document the missed appointment in the members' medical record. You should make at least three attempts to contact members to determine the reason for the missed appointment. The medical record should reflect the reason for any delays in performing an examination, including any refusals by the member. Documentation of the attempts to schedule an initial health assessment should be available to Healthy Blue or state reviewers upon request.

AFTER-HOURS SERVICES

Healthy Blue members have access to quality, comprehensive health care services 24 hours a day, seven days a week. Members can call their PCP with a request for medical assessment after normal office hours. We require PCPs to have an after-hours system in place to ensure members can reach the physician or an on-call physician with medical concerns or questions. We require an answering service or after-hours personnel to forward member calls directly to the PCP or on-call physician or instruct the member that the provider will contact the member within 30 minutes.

We require the answering service or after-hours personnel to ask the member if the call is an emergency. In the event of an emergency, we require them to immediately direct the member to dial 911 or to proceed directly to the nearest hospital ER.

If staff or an answering service is not immediately available, an answering machine can be used but should instruct members to hang up and dial 911 or go to the nearest ER for emergency issues. Further, answering machine instructions should direct the member to an alternate contact number (or system prompt) so the member can reach the physician or on-call provider after regular business hours.

We prefer PCPs use a Healthy Blue-contracted in-network physician for on-call services. When this is not possible, we require PCPs ensure the covering, noncontracted, on-call physician abides by the terms of the provider contract.

We monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply with after-hours access standards may result in corrective action.

For after-hours linguistic access, providers should accommodate non-English speaking members by making office answering machines available with multilingual messages containing language appropriate care instructions.

These instructions direct the member to dial 911 or to proceed directly to the nearest hospital ER in an emergency or stay on the line while being transferred to an answering service registered nurse who will contact a telephone interpreter. Professional answering service personnel and on-call personnel should be trained on how to access interpreter services.

ER PROTOCOL REPORTING PROCESS

Healthy Blue has implemented a system to report any difficulties experienced with the 24-Hour Nurseline or plan emergency care systems or protocol failures. Please contact Provider Service at 866-757-8286 to report any failures. We request corrective action plans from contracted network hospitals that have ERs that fail to meet our contractual obligations or follow our ER protocols.

CONTINUED ACCESS TO CARE/CONTINUITY OF CARE

We allow new members transitioning from fee-for-service Medicaid to receive services from out-of-network providers if they contact Healthy Blue to discuss their scheduled health services in advance of the service date and if one of the following qualifying conditions exist:

- We approved and scheduled the member to receive an organ transplant or tissue replacement.
- The member is pregnant and has an established relationship with an obstetrician and/or delivery hospital.
- The member has been scheduled for inpatient/outpatient surgery and has prior SCDHHS approval and/or PA through the applicable process.
- The member has appointments within the initial month of Healthy Blue membership with specialty physicians who were scheduled prior to the effective date of Healthy Blue membership.
- The member is receiving ongoing chemotherapy or radiation treatment.

We will cover these out-of-network providers at 100 percent of the current Medicaid provider rate for that service.

All new enrollees receive EOC information in their enrollment packets. The EOC also provides information about their rights to request continuity of care.

PHYSICIAN CONTRACT TERMINATION

We require a terminated physician or provider who is actively treating members to continue to treat members until their termination date. We require the provider to follow the terms of the Provider Agreement for providing notice for the nonrenewal or termination of the agreement. The effective date for the nonrenewal or termination should be the last day of the month.

Once Healthy Blue receives a physician's notice to terminate a contract, we notify members affected by the termination of a physician or provider. We send a letter in writing at least 30 days in advance to inform the affected members of:

- The impending termination of their physician(s) or provider(s).
- Their right to request continued access to care.
- The Provider Service phone number to make PCP changes and/or forward referrals to case management for continued access-to-care consideration.

Healthy Blue is required to arrange for continuity of care by the terminating PCP for members who need continued access to care. The PCP or members can call Provider Service or the TTY line for members with hearing loss. Refer to the Important Contact Information section in this manual for those telephone numbers.

Members under the care of specialists can also submit requests for continued access to care, including continued care after the transition period, by calling Provider Service via the numbers listed in Important Contact Information section. They should request case management referral for continuity of care.

DISENROLLEES

It is the responsibility of the case manager to help a member who is disenrolling with transitioning case management assistance to another health plan. This must happen without disruption of a regimen of care that qualifies as a continuity-of-care condition. The case manager works with the member, involved physicians and the case manager at the new health plan to ensure an orderly transition.

Continuity-of-care process

Case management nurses review member and provider requests for continuity of care and facilitate continuation with the current physician until the short-term regimen of care is completed or the member transitions to a new practitioner as long as the member has a qualifying condition.

CLINICAL PRACTICE & PREVENTIVE HEALTH GUIDELINES

Healthy Blue supports physicians in following the current nattionally accepted Clinical Practice Guidelines from recognized sources to improve the health of Healthy Blue members. Healthy Blue adopts nationally recognized Clinical Practice Guidelines for asthma, diabetes, hypertension, and other conditions.

Good health begins with good lifestyle habits and regular exams. Preventive Health Guidelines help providers keep members on track with necessary screenings and exams based on age and gender.

Several national organizations produce guidelines for preventive health screenings, immunizations, and counseling.

Healthy Blue provides a summary of Preventive Health Guidelines for members in the Evidence of Coverage and on our website, www.HealthyBlueSC.com. Healthy Blue also makes these guidelines available to members and potential members upon request.

Healthy Blue has reviewed and recommends the guidelines based on:

- Valid and reliable clinical evidence or a consensus of health care professionals in the relevant fields.
- The best interest of the members.
- Adoption in consultation with contracting health care professionals through the CQIC.
- Annual reviews and updates as appropriate.

Healthy Blue disseminates these guidelines to all contracted providers through the Healthy Blue website. Providers can find the recommended Clinical Practice Guidelines and Preventive Health Guidelines at www.HealthyBlueSC.com. Clinical Practice Guidelines are also available to members and potential members upon request. If the provider does not have internet access, he or she can contact Provider Service at 866-757-8286.

Our recommendation of these guidelines does not constitute an authorization, certification, Explanation of Benefits or contract. Benefits and eligibility are determined in accordance with the requirements set forth by the state.

HEALTH EDUCATION & MANAGEMENT

HEALTH SERVICES AND PROGRAMS

Our Health Services department seeks to improve the health and overall well-being of Healthy Blue members by offering health education and health management programs that educate, inform and encourage self-care. Educational interventions assist members in:

- The effective use of the managed care system, preventive and primary health services, health education services, and appropriate use of complementary and alternative care.
- Working with their PCPs in the management of their personal health care.
- Achieving and maintaining healthy lifestyles.
- Promoting positive health outcomes.

Health education and management programs help members learn about and follow self-care regimens and treatment therapies for existing medical conditions and chronic diseases or health conditions, including programs for pregnancy, asthma and diabetes. Healthy Blue then uses a variety of methods to communicate health services information to members, including:

- PCPs who refer members to available and applicable programs.
- Phone calls (outbound and inbound).
- Written materials.
- Direct mailings.
- Participation in health fairs and community events.
- Our website, www.HealthyBlueSC.com.

No-cost classes available to members

Healthy Blue supports health education classes that take place at hospitals and community-based organizations. Classes are free to members and are accessible upon self-referral or referral by contracted providers. Classes vary from county to county. Some of the classes Healthy Blue provides include:

- Asthma management.
- Childbirth preparation.
- Diabetes management.
- Nutrition.
- Weight management.
- Parenting/well child.
- Prenatal & Postpartum education.
- Smoking cessation/tobacco prevention.

How to schedule health education classes

Members get information about health education classes through enrollment materials, member newsletters and provider offices. Members should call our Health Management and Education department at 866-781-5094 to schedule a health education class.

Follow-up

After each class, Healthy Blue sends an Attendance Confirmation letter to the member's PCP with the member's name, ID number and the title of class attended. If a member does not show up for the registered class, Healthy Blue mails a no-show letter to the member's PCP. PCPs should, but are not required to, document health education services in the member's medical record.

How to get health education materials for the provider's office

Healthy Blue supplies providers with health education materials developed for varying cultural and linguistic needs. To request health education materials, call Provider Service at 866-757-8286.

INITIAL HEALTH ASSESSMENT (IHA)

PCPs should perform an IHA with new members. The IHA consists of:

- A history and physical examination.
- A developmental assessment.

An IHA is not necessary if the member is an existing patient of the PCP group. Transferred medical records can meet the requirements for an IHA if a completed health history is included.

24-HOUR NURSELINE: THE NURSE INFORMATION LINE

How the nurse information line assists members

24-Hour Nurseline is a phone help line staffed by registered nurses who can help members with health-related questions. The 24-Hour Nurseline is available 24 hours a day, seven days a week. The phone number is **800-830-1525**.

Members can contact the 24-Hour Nurseline for:

- Assistance with self-care information, such as symptom triage, medications and side effects, and reliable self-care home treatments.
- Information on hundreds of health topics through the 24-Hour Nurseline audio tape library.
- Information from nurses trained to discuss pediatric, adolescent and teen issues.

The nurses at the 24-Hour Nurseline have access to an interpreter service for callers who do not speak English. All calls are confidential.

How the 24-Hour Nurseline supports providers

Providers can inform their patients about the toll-free 24-Hour Nurseline service for urgent, educational or general health questions.

The 24-Hour Nurseline provides general information only, not medical advice. If a Healthy Blue member needs emergency health care, he or she should call 911 right away.

PREVENTIVE CARE PROGRAMS

Healthy Blue has developed preventive care programs to help promote and maintain good health for members and to remind members about the importance of regular checkups. Providers are an integral part of these programs. Although the programs target different health issues, they all share the same goal of helping members live healthier lives.

EPSDT Program

We provide well-child checkups for Medicaid-eligible children from birth through the month of their 21st birthday in compliance with federally mandated EPSDT program guidelines. PCPs offer age-appropriate preventive care screening and testing during each well-child checkup and during an acute illness episode if appropriate.

EPSDT Program screening requirements

The EPSDT Program includes the following periodicity and screening requirements:

- A comprehensive health and developmental history
- A comprehensive unclothed physical exam
- Appropriate immunizations
- Laboratory tests
- Blood pressure
- Sensory screening (vision and hearing)
- Dental assessment
- Anemia screening
- Lead toxicity screenings

Healthy Blue responsibilities

Healthy Blue maintains intervention strategies to keep members current with their EPSDT Program and American Academy of Pediatrics (AAP) Periodicity Schedules, including reminding members of:

- Immunizations for members under age 2.
- Preventive care for members ages 2 – 20 in their birth months.

Provider responsibilities

The list below details the responsibilities of providers who help members maintain healthy lifestyles:

- Document all health care screenings, immunizations, procedures, health education and
- counseling in member medical records.
- Schedule preventive care appointments for all members under age 21 following the AAP Periodicity Schedule.
- Provide immunizations, as needed, at all well-child visits and according to the schedule established by the Advisory Committee on Immunization Practices, American Academy of Family Physicians and AAP.
- Refer members to county health departments and maintain a record of each child's immunization status, if you do not routinely administer immunizations as part of your practice.
- Report the required immunization information data to the State Immunization Information System (SIIS) administered by the South Carolina Department of Health and Environmental Control effective with the implementation of SIIS.
- Refer members, as appropriate, to dentists, optometrists/ophthalmologists or other specialists as needed and as allowed by benefits. Document referrals in the member medical records.

Well-Woman Program

The Healthy Blue Well-Woman Program encourages women to have regular cervical and breast cancer screenings. The program reminds and encourages women to call their PCPs to make an appointment to schedule screenings.

Access to women's health specialists

If the PCP is not a women's health specialist, Healthy Blue provides all female members with direct access to in-network women's health specialists for covered routine and preventive health care services.

Members have the right to receive family planning services, not including routine care, from any Medicaid provider. In addition, members also have the right to receive tuberculosis, sexually transmitted diseases and HIV/AIDS care from any public health agency.

Physician care for women

PCP responsibilities for the care of female members include:

- Informing and referring members for cervical and breast cancer screenings.
- Educating members on Preventive Care Guidelines for women.
- Scheduling screening exams for members.

Providers can access our Preventive Health Care Guidelines in Clinical Practices and Preventive Health Care Guidelines of this manual. These guidelines are also on our website www.HealthyBlueSC.com.

HEALTH EDUCATION PROGRAMS

Program overview

To assist you in helping members improve and manage their health, Healthy Blue developed several health education programs to address members' health statuses and conditions. Refer to the section titled, "How to get health education materials for the provider's office" in this chapter for information about how to order education material. Refer to our website www.HealthyBlueSC.com for more information.

Tobacco Cessation Program

Our Tobacco Cessation Program offers numerous resources and tools to assist members who want to quit smoking. This program helps members in any stage of cessation readiness and includes:

- Written materials focusing on education, tools and tips to help members quit smoking.
- Resources available through the South Carolina Quit Line, which offers members phone and internet support as well as a personalized quit plan with a quit coach. The South Carolina Quit Line is 800-QUIT-NOW (800-784-8669) and its website is www.scdhec.gov/health/tobacco-cessation/info-healthcare-providers.
- Help locating community classes focused on smoking cessation for members enrolled in the Chronic Condition Care Program.

Tobacco cessation counseling in individual and group settings is covered when billed with CPT codes 99406 and 99407. Reimbursement for counseling is limited to four sessions per quit attempt for up to two quit attempts each year.

Weight Management Program

Healthy Blue recognizes the importance a proper body weight has on the overall health and well-being of our members. Eligible members can receive weight management program assistance through Internal Wellness Weight Management program. For more information about this program, call Provider Service at 866-757-8286.

HEALTH MANAGEMENT PROGRAMS

Condition Care/Population Health Programs

We base our Condition Care/Population Health (CC/PH) Programs on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions. CC/PH services include a holistic approach, focusing on the needs of the member through telephonic and community-based resources.

Motivational interviewing techniques are used in conjunction with member self-empowerment to enhance the ability to manage more than one condition to meet the changing health care needs of our member population.

Who is eligible for CC/PHP?

Members diagnosed with one or more of the conditions listed below are eligible:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder
- Congestive heart failure
- Coronary artery disease
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult and child/adolescent
- Schizophrenia
- Substance use disorder

In addition to our condition-specific CC/PH Programs, our member-centric approach allows us to manage members with smoking cessation and weight management education.

Program features:

- Proactive population identification process
- Program content based on evidence-based Clinical Practice Guidelines
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing communication with primary and ancillary providers about patient status

Nine of our Condition Care programs are accredited by the National Committee for Quality Assurance. They incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

We welcome provider referrals of those who could benefit from additional education and care management support. Our case managers work with you to get input in the development of care plans and provide telephonic and/or written updates and progress. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their condition. They get continuous education on self-management concepts, including primary prevention, coaching related to healthy behaviors and compliance/monitoring. We also offer case/care management for high-risk members.

CC/PHP provider rights and responsibilities

Providers have the right to:

- Have information about Healthy Blue, including:
  - Provided programs and services.
  - Our staff.
  - Our staff's qualifications.
  - Any contractual relationships.
- Decline to participate in or work with any of our programs and services for your patients.
- Be informed of how we coordinate our interventions with your patients' treatment plans.
- Know how to contact the person who manages and communicates with your patients.
- Be supported by our organization when interacting with patients to make decisions about their health care.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints about CC (see our provider complaint and grievance procedure).

Contact information

You can email us at HBProviderService@healthybluesc.com or call 866-757-8286.

PREGNANCY PREVENTION

Medicaid Adolescent Pregnancy Prevention Services (MAPPS) provide Medicaid-funded family planning services to at-risk youth. We designed MAPPS to prevent teenage pregnancy among at-risk youth, promote abstinence and educate youth to make responsible decisions about sexual activity, including postponement of sexual activity or the use of effective contraception. Services provided through this program include:

- Assessments.
- Service plans.
- Counseling.
- Education.

Services are provided in schools, offices, homes and other approved settings. Call the SCDHHS at 803-898-2655 for more information.

MATERNITY PROGRAM

Maternity Program is a proactive case management program for all expectant mothers and their newborns. It uses extensive methods to identify pregnant women as early in their pregnancy as possible through review of state enrollment files, claims data, hospital census reports, Pregnancy Notification Report forms, and provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest-risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, home visitor programs, breastfeeding support and counseling. Find out more about transportation services through ModivCare at www.modivare.com or www.scdhhs.gov/transporation-beneficiary-information.

ModivCare is an independent company that provides transportation services on behalf of BlueChoice HealthPlan.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in our Maternity Program. It's a comprehensive case management and care coordination program that offers:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

The main objectives of the Maternity Program are to help members achieve positive birth outcomes, encourage early and ongoing prenatal and postpartum care, and increase member access to perinatal care. By completing the Pregnancy Notification Report form, pregnant women are

automatically enrolled into the Maternity Program. The Pregnancy Notification Report form can be completed online or by printing the form and faxing it to us at 800-823-5520 when complete. To complete the online version, log into My Insurance Manager.

We accept a pregnancy notification at any time during a member's pregnancy. It's important that we get this notification as early in the pregnancy as possible. Immediately after the first prenatal visit is ideal.

We require facilities to notify us of delivery within 24 hours of birth using the Notification of Delivery or agreed-upon format. Information includes date of birth, gestational age, live birth, weight and gender.

NICU CASE MANAGEMENT PROGRAM

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the NICU Case Management Program. The NICU Case Management Program provides education and support designed to help with the day-to-day stress of having a baby in the NICU, encourages parent/caregiver involvement, and helps them prepare themselves and their homes for discharge. Parents/caregivers get education and resources that outline successful strategies they may use to collaborate with the baby's NICU care team while in the hospital and manage their baby's health after discharge.

Once discharged, NICU case managers continue to provide parent/caregiver education and support to foster improved outcomes, prevent unnecessary hospital readmissions and promote efficient community resource consumption as needed.

BIRTH OUTCOMES INITIATIVE

To improve health outcomes of our newborn members, Healthy Blue partners with the SCDHHS, the South Carolina Hospital Association (SCHA), the March of Dimes, other public and private agencies, providers, payers, and consumers to implement the Birth Outcomes Initiative.

This state-mandated initiative focuses on reducing the number babies with low birth weights. It has six key goals:

- End elective inductions for deliveries prior to 39 weeks. This should help us reduce the number of cesarean sections and NICU admissions.
- Reduce the average length of stays in NICUs and pediatric intensive care units.
- Reduce health disparities among newborns of varying ethnic groups.
- Implement a universal screening, brief intervention and referral to treatment for physicians. This tool screens pregnant women for tobacco use, substance abuse, depression and domestic violence.

The SCDHHS and SCHA secured written commitments from all 43 of the state's birthing hospitals stating they would end the practice of elective deliveries and inductions prior to 39 weeks gestation. Substantial clinical support indicates early deliveries contribute to substandard health outcomes for children as well as costly NICU stays.

Safety Checklist for Early Births

When you are scheduling an induction or planned cesarean section for deliveries at less than 39 weeks gestation, we require you to complete the American College of Obstetricians and Gynecologists (ACOG) Patient Safety Checklist or comparable patient safety justification form. You are also responsible for maintaining a copy of this documentation in your files and in the hospital records that are subject to SCDHHS program integrity review.

Copies of ACOG- and Birth Outcomes Initiative-approved delivery guidelines, which justify elective inductions and deliveries prior to 39 weeks gestation, as well as the ACOG Patient Safety Checklist are located online on the SCDHHS website. To access the ACOG Patient Safety Checklist and the approved Birth Outcome Initiative Medically Necessary Guidelines, go to www.scdhhs.gov/provider-manual-list and scroll down to **Physicians Services Provider Manual** and **Hospital Services Manual**.

Approved guidelines for delivery at less than 39 weeks gestation

The following conditions are generally accepted as exceptions to the guideline recommendation for planned delivery or induction no earlier than 39 weeks. Delivery at less than 39 weeks for these conditions may represent a benefit for the mother, the fetus or both. This list is not meant to be exclusive, and each category may require a separate guideline to outline evidence-based practices about timing or delivery:

- Allo-immune thrombocytopenia
- Cholestasis of pregnancy
- Chorioamnionitis
- Fetal gastroschisis
- Fetal iso-immunization
- Herpes gestationis
- HIV
- Impetigo herpetiformis
- Intra-uterine growth restriction
- Maternal death (peri-mortem delivery)
- Maternal malignancy
- Multiple gestation
- Nonreassuring fetal status
- Oligohydramnios
- Other congenital anomalies requiring early delivery (for instance, Vein of Galen malformation)
- Placenta previa/accreta/percreta
- Placental abruption
- Poorly controlled diabetes mellitus
- Preeclampsia, mild or severe
- Premature rupture of the membranes
- Preterm premature rupture of the membranes
- Prior classical cesarean delivery (prior incisions into the muscular uterus)
- Prior myomectomy, uterine rupture or significant scarring
- Severe maternal hemorrhage
- Uncontrollable chronic hypertension or gestational hypertension
- Vasa previa
- Worsening maternal medical condition (renal failure, respiratory distress syndrome, acidosis, etc.)

For information on proper billing of vaginal deliveries and cesarean section, please see the section titled, “Early birth modifiers” under Billing Professional and Ancillary Claims.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM STRUCTURE

QAPI Program scope

The QAPI Program includes the development and implementation of standards for clinical care and service, measuring conformity to those standards, and taking action to improve performance. Refer to our website, www.HealthyBlueSC.com.

QAPI Program work plan and annual evaluation

Healthy Blue develops an annual work plan of activities based on the results of the previous year's QAPI Program. Healthy Blue reviews and assesses the QAPI Program's effectiveness on an annual basis during the program's evaluation. The evaluation is a written description of our ability to implement the QAPI Program, meet program objectives, and develop and implement plans to improve the quality of care and service to members.

Detailed information about our progress in meeting its goals is available in the annual program evaluation. A hard copy of any of the documents mentioned is available upon request by calling Provider Service at 866-757-8286.

What providers can do to support the QAPI Program

Refer to our website www.HealthyBlueSC.com for more information.

PRACTITIONER/PROVIDER PERFORMANCE DATA

Practitioners and providers must allow Healthy Blue to use performance data in cooperation with our quality improvement program and activities.

Practitioner/provider performance data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual health care practitioner, such as a physician, or a health care organization, such as a hospital. Common examples of performance data would include the HEDIS Quality of Care Measures maintained by the NCQA and the comprehensive set of measures maintained by the National Quality Forum.

Practitioner/provider performance data may be used for multiple plan programs and initiatives, including but not limited to:

- Reward programs — Pay-for-performance (P4P), pay-for-value (PFV) and other results-based reimbursement programs tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- Recognition programs — Programs are designed to transparently identify high-value providers and facilities and make that information available to consumers, employers, peer practitioners and other health care stakeholders.
- Educational opportunities — By assessing performance data, the Quality department can help educate practitioners/providers on proper medical record documentation for those HEDIS measures maintained by the NCQA that are often adjusted due to changes in population, health care costs and other identifiers.

Advance directives

Healthy Blue notifies members of their right to execute advance directives, such as a living will or durable power of attorney for health care, to identify their wishes concerning health care treatment and decisions should they become incapacitated. They are also informed of their right to change or revoke an advance directive at any time.

You may be asked to assist members in procuring and completing necessary forms. Refer to our website at www.HealthyBlueSC.com and select Providers for more information.

Preventable adverse events

The breadth and complexity of today's health care system means there are inherent risks, many of which can be neither predicted nor prevented. The occurrence of preventable adverse events should be tracked and reduced with the ultimate goal being to eliminate them.

As patient providers and advocates, physicians and health care systems are responsible for the continuous monitoring, implementation and enforcement of applicable standards. Preventable adverse events should not occur. We firmly support the concept that a health plan and patients should not pay for services that resulted from a preventable adverse event.

We continue to monitor activities related to the list of adverse events from federal, state and private payers. HIPAA regulations specify personal health information can be disclosed for the purpose of health care operations in relation to quality assessment and improvement activities. Also, the information providers share with us is legally protected through the peer review process. It will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide those records within 10 days from the date of request.

CULTURAL COMPETENCY

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Patient panels are increasingly diverse, and needs are becoming more complex. It is important to have the knowledge, resources and tools to offer culturally competent and linguistically appropriate care. Healthy Blue wants to help as we all work together to achieve health equity.

The U.S. Department of Health and Human Services defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that health care is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed and how symptoms are described.
- Expectations of care and treatment options.
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including but not limited to the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met.
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for patients with limited English proficiency.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans With Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Healthy Blue ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. We encourage you to access and use the following resources:

MyDiversePatients.com: The My Diverse Patient website at www.MyDiversePatients.com offers resources, information and techniques to help provide the individualized care every patient deserves, regardless of his or her diverse background. The site also includes learning experiences on topics related to cultural competency and disparities that offer free continuing medical education (CME) credit. Current CME offerings include:

- Caring for Children With ADHD: This promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; and awareness of and strategies for addressing disparities.
- Creating an LGBT-Friendly Practice: This helps you understand the fears and anxieties LGBT patients often feel about seeking medical care, learn key health concerns of LGBT patients, and develop strategies for providing effective health care to LGBT patients.
- Improving the Patient Experience: This helps you identify opportunities and strategies to improve patient experience during a health care encounter.
- Medication Adherence: This helps you identify contributing factors to medication adherence disparities for diverse populations and learn techniques to improve patient-centered communication to support needs of diverse patients.
- Moving Toward Equity in Asthma Care: This helps you understand issues often faced by diverse patients with asthma and develop strategies for communicating to enhance patient understanding.
- Reducing Health Care Stereotype Threat (HCST): This helps you understand HCST and the implications for diverse patients. It also helps you understand the benefits of reducing HCST for both your patients and practices and how to do so.

- Cultural Competency Training (Cultural Competency and Patient Engagement): This training resource increases cultural and disability competency to help effectively support the health and health care needs of your diverse patients.
- Caring for Diverse Populations Toolkit: This comprehensive resource helps you and your office staff increase effective communication by enhancing knowledge of the values, beliefs and needs of diverse patients.

See the Interpreter Services section for language support information.

Healthy Blue appreciates the shared commitment to ensure members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross Blue Shield Association.

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